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FINAL REPORT

# "A MONTANA PROJECT TO DEVELOP A SINGLE INDICATOR OF MEDICAID MANAGEMENT"

GRANT # 11-P-90739-18-01

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October 1, 1977 Through September 30, 1978

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Acknowledgments

This is the final report of the Montana Medicaid Quality Control Project. The project was funded through an HEW, HCFA 1115 Demonstration Grant #11-P-90739 18-01 entitled "A Montana Project to Develop a Single Performance Indicator of Medicaid Management."

The Project staff would like to extend their appreciation to the many individuals in SRS who provided assistance to the Project, especially to the staff of:

Director's Office

Economic Assistance Division

Statistics and Research Bureau

Data Processing Bureau

Fiscal Bureau

The project would also like to extend special thanks to the following:

Jack Carlson, Administrator, Economic Assistance Division

Jim McCabe, Bureau Chief, Program Integrity

Ann Murray, Quality Control Supervisor, Program Integrity

Jared Davis, Recoveries Section Supervisor, Program Integrity

Anna Marie Bartole, Program Manager, Program Integrity

Doug Egan, Bureau Chief, Statistics and Research

David Selleck, DHEW Quality Control

Chris Manger, Program Analyst, Director's Office

Franklin Smoyer, Consultant, Helena, Montana

Control Analysis Corporation Consultants, Palo Alto, California

The project would further like to express our gratitude to Bob Morgan for his efforts in this report and throughout the process, to the Claims Examiners for

development of the Claims Processing/Third Party Liability process and their contributions to this report. We would also like to thank the Medicaid Quality Control Reviewers, both Project and State staff, for their contribution to the process, as well as Debra Richter who typed this report.

I. INTRODUCTION:

This report, compiled by Title 1115 Project Staff, is submitted in narrative form and includes project activities, implementation activities, and implementation recommendations based on Montana's experience in the Project process.

A. Purpose

The purpose of this report is to evaluate the project process and to make recommendations for MQC implementation improvement.

B. Background of the Project

In July 1977, the Department of Health, Education, and Welfare, Health Care Financing Administration, Evaluations Branch, began soliciting states for one year demonstrations to determine the feasibility of implementing Medicaid Performance Standards in the areas of uncollected third party liability and erroneous payments. On August 16, 1977, a proposal was submitted to HCFA under Title XI, Section 1115 for "A Montana Project to Develop a Single Performance Indicator of Medicaid Management." On October 6, 1977, Montana was notified that the grant proposal and application number 11-P-90739/8-01 was approved for a period of one year, October 1, 1977, through September 30, 1978.

C. Existing Organization-MEQC

In July 1975, the State of Montana, partially funded by a Section 1115 Demonstration Grant, chose a modified approach in undertaking the development of a Medicaid Quality Control System. The Montana process included a random sample of 800 claims per six month period. The sample was stratified to include institutional and noninstitutional claims. The Review process included four review levels as follows: 1) Central Office Review, 2) Local Office Case Review, 3) Local Office Abbreviated Field

Review, and 4) Full Field Review. To accomplish this review process, the staffing pattern included:

1 Program Manager

1 Research Specialist

8 Field Quality Control Reviewers

In July 1977, when the MEQC Project ended, three Medicaid Quality Control Reviewers were assimilated into the existing Quality Control Unit. The reviewer staff was trained then for generic reviews to include eligibility review of Medicaid, Aid to Dependent Children, and Food Stamps. The sample was reduced to the 175 federal requirement and the full field investigation review process. The sample continued on a claim basis with random selection of institutional, noninstitutional claims.

To accomplish this review process as well as a sample of Food Stamp and AFDC cases, the staffing pattern included:

1 Quality Control Supervisor

1 Program Manager

10 Quality Control Field Reviewers

II. PROGRAM OPERATIONS - MQC PROJECT:

This section describes the organization, staff background, staff needed for the ongoing process, implementation steps, and accomplishments.

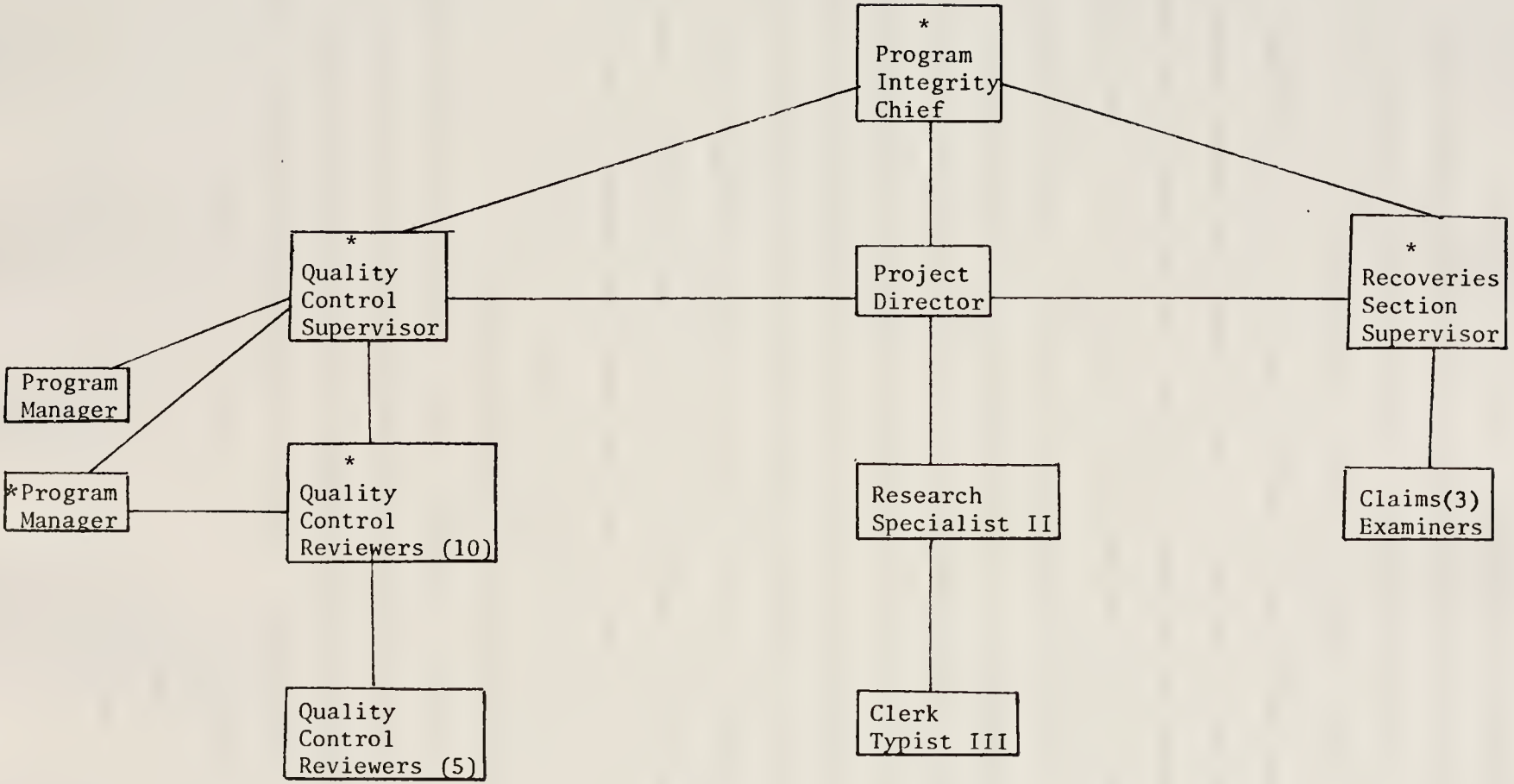
A. Organization

In order to implement the MQC Project, a combination of existing Program Integrity Bureau staff and twelve new employees were utilized to develop the expanded process. The Bureau Chief of the Program Integrity Bureau, Quality Control Supervisor, Quality Control Program Manager, Recoveries Section Supervisor, and ten Quality Control Field Reviewers worked directly with the project. Attached is Exhibit A, a flow chart of the project organization. The following are the employees hired for project purposes:

| Job Title | Date of Hire |
|---|---|
| Project Director | 10-27-77 |
| Research Specialist | 11-15-77 |
| Clerk Typist | 11-16-77 |
| Program Manager I | 11-07-77 |
| 2 Claims Examiners | 11-21-77 |
| 1 Claims Examiner | 12-05-77 |
| 5 Quality Control Field Reviewers | 11-21-77 |

One of the Field Reviewers resigned as of 3-29-78 and the Program Manager resigned 6-9-78. Both positions were left vacant.

PROJECT STAFFING PATTERN




* designates state staff who directly worked with the Project



(Exhibit A)

B. Staff Background and Skills

The Project Director had worked for Quality Control and had Eligibility Technician experience. She had formerly worked for another Pilot Test Project with the Blackfeet Indian Tribe.

The Research Specialist had a background in social services and social work, having worked as a social worker with youths, giving him familiarity with social service programs. He completed graduate studies in program administration and evaluation, with emphasis on social service research. He worked on some research projects in graduate school, and had some introductory data processing and data analysis knowledge.

The five field reviewers had previous experience with Social and Rehabilitation Services. Two reviewers had Eligibility Technician background while the remaining three had worked in other areas of the Agency.

Of the three Claims Examiners hired, each brought with them a special contribution to the process. One had worked for Medicaid Provider Information, another had worked as an Eligibility Technician, and the third was familiar with the Medical Assistance Program through working in the Economic Assistance Division.

C. Staff Skills Needed for the Ongoing Process

After discussion, planning, and a hiring freeze, the Program Integrity Bureau recommended that four positions be retained at the end of the project for implementation of the ongoing MQC process. The following positions were requested and approved by the Office of Budget and Program Planning.

1 Research Specialist

2 Claims Examiners

1 Clerk Typist

The Research Specialist will pull the monthly sample, verify reliability of the sample, match sampled recipients' cases with the paid claims tape, provide data to the Claims Examiners. In addition, the Research Specialist will develop a computer file for review schedule information, edit review schedules to insure data reliability, supervise data processing functions and correct, update, and maintain data files. The Research Specialist will also prepare the eleven Medicaid Quality Control reports, corrective action reports, and will assist with computer processes and statistical needs in the Program Integrity Bureau.

The two Claims Examiners will conduct third party liability (TPL) review and examine claims processing (CP) for all recipients in the 175 MAO cases, 150 ADC cases, and 120 SSI cases.

The Clerk Typist will maintain case ledgers, the case tracking system, will perform the clerical functions of case transmittals, and will type TPL inquiries, reports, and correspondence for the bureau.

The MQC process will be carried under the Program Integrity Bureau in the Economic Assistance Division.

D. Implementation Steps/Accomplishments

The implementation steps outlined in the Montana Work Plan were completed as follows:

1. Recruited project staff;
2. Secured office equipment, office space, telephone and supplies for the project staff,
3. Hired project staff,
4. Sampled 600 cases of MAO, SSI, and ADC recipients on a case basis for the period 4-77 through 9-77,

5. Developed a Third Party Review process;

6. Developed a claims review process;

7. Trained five field staff Quality Control Reviewers to conduct Medicaid reviews;

8. Trained three Claims Examiners, and assisted in the development of the CP and TPL review;

9. Compiled, analyzed, and developed supporting manuals, material and data for CP and TPL review;

10. Met with Dikewood Corporation (fiscal intermediary) and PSRO (Professional Services Review Organization) to develop a liaison for CP and TPL review and to gather material for decoding claims;

11. Developed a system to obtain all claims for the recipients in the review cases for the service month and six months forward. Paid claims information was obtained from the Dikewood paid claims tape and the original claim printed from microfilm of the claim;

12. Contracted evaluation of systems and project accomplishments with Control Analysis Corporation, Franklin Smoyer Company, and Jerry Smith-Management Analyst;

13. Conducted time-study of Claims Examiner TPL and CP review;

14. Developed a workable review schedule for data collection and reporting;

15. Developed logging system for case tracking from Eligibility Review to CP and TPL review;

16. Developed form letters for obtaining information for TPL review;

17. Developed form letters for referral and information purposes;

18. Developed procedures for interface with Quality Assurance Reviews for SSI cases (an interface of coding procedures was necessary to cite errors in the MQC system);

19. Developed procedures for testing Aid to Dependent Children and Supplementary Security Income case ineligibilities for Medical Assistance Only Eligibility;

20. Completed monthly project reports beginning November 1977, and ending July 1978;

21. Developed Procedures Manual for implementation of the new Medicaid Quality Control Process.

The accomplishments of this Title 1115 Project can be summarized by saying that the Medicaid Quality Control Process developed a procedure to pinpoint previously unidentified dollar losses. Prior to the pilot test, dollar losses were estimated in the single program of Medical Assistance Only through a review of recipient eligibility. The expanded process includes medical reviews in the programs of Medical Assistance Only, Aid to Dependent Children, and Supplementary Security Income. The three program reviews identify dollars misspent through recipient ineligibility, liability understated, Third Party Liability not collected and where Medicaid claims were paid improperly. The new process has produced a single Medicaid indicator of dollar losses by combining all facets of the program. The program, as a management tool, now identifies Medicaid expenditure problems for error correction. Correction of system problems and recovery of misspent dollars will benefit the State of Montana through cost containment in the Medicaid Program.

The following is a description of the specific tasks and activities which resulted in the before mentioned accomplishments. A time phased

narrative outlines accomplishments throughout the process using a monthly reporting format:

October, 1977

1. During October 1977, a Project Director was recruited and hired.

November, 1977

1. During this month, a time phased, detailed work plan was completed outlining the development of the processes of the project.

2. A budget amendment proposal was written and submitted for an additional $40,000 contract to Control Analysis Corporation for Technical Assistance and Project Evaluation.

3. Staff (as outlined under the Organization section) were recruited and hired by November 21, 1977. Job functions and descriptions were developed for the new positions created by the project.

4. An office for six staff persons was obtained in the Helena SRS building. Three project Field Reviewers moved into existing field offices. New offices were established in Miles City and Bozeman for Quality Control Reviewers.

5. Office equipment was purchased for staff use. Two desks, a typewriter, calculators, chairs, and file cabinets were purchased. The remaining equipment necessary was borrowed from agency storage.

6. Preliminary plans were made for the development of a contract with Jerry Smith, Computer Programmer, for completion of Tasks as outlined by Central office.

7. State staff met with federal staff to develop procedures. A retroactive sample of cases for MAO, SSI, and ADC was chosen from

the period 4-77 through 9-77 for project purposes. The AFDC sample, for the period, as well as the Quality Assurance sample, for the same period, were used for project purposes.

8. An elaborate logging system was developed by the quality control section and the project section to track cases from assignment to field review, to original edit, to CP-TPL review, to final edit, to re-review, and back to reporting (a flow chart of the tracking system is included as exhibit B & C.).

9. From 11-29-77 to 12-1-77, David Selleck, from Denver Regional office, DHEW, conducted training for new staff. Quality Control Reviewers were trained to conduct case basis reviews, on methods of obtaining documentation, and case completion. Jared Davis, Recoveries Supervisor, gave the Claims Examiners an overview of the Dikewood claims processing system.

December, 1977

1. For the first time during December Medicaid Quality Control Reviews were completed on a case basis rather than claims basis review.

2. On-site meetings of Helena project staff with the Montana Foundation for Medical Care and Dikewood Corporation were made during this month. The following materials were gathered for support material for the Claims Processing function:

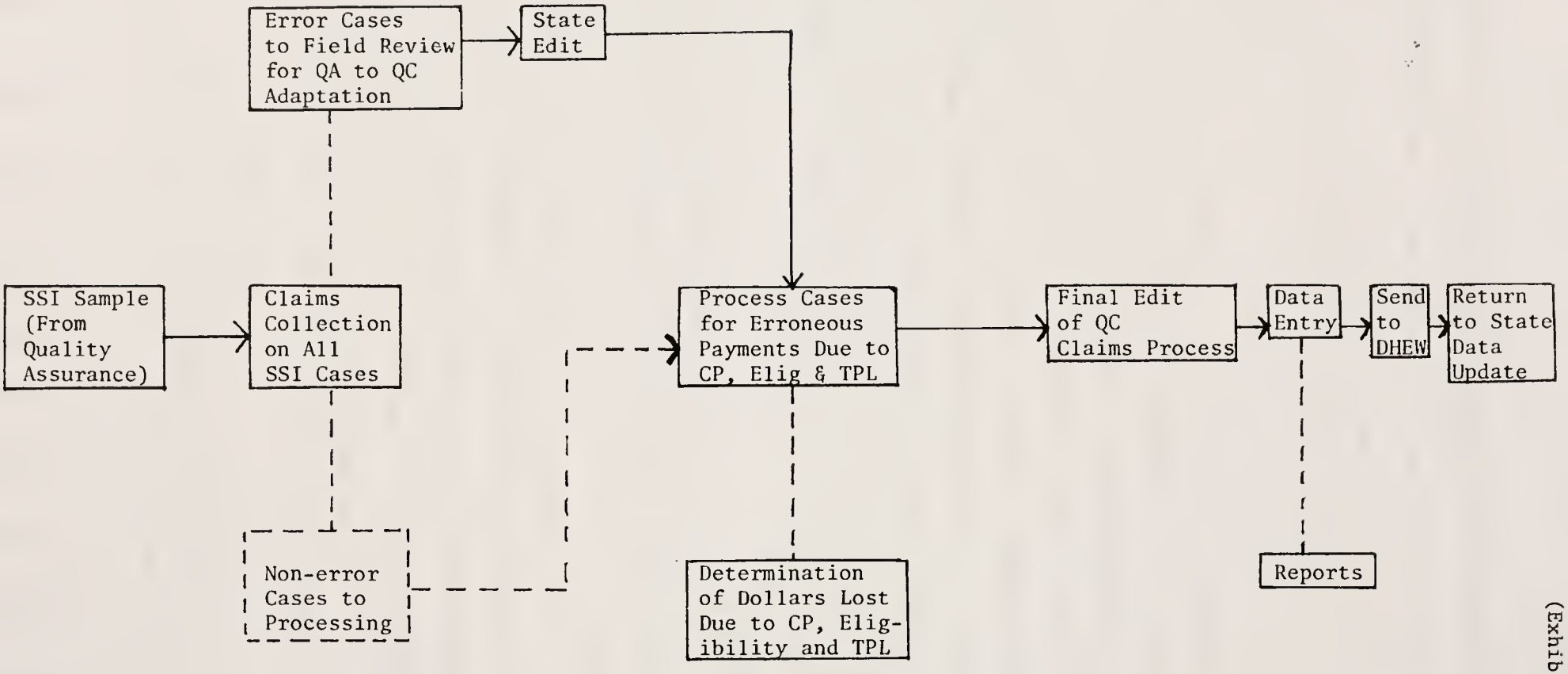
a. Montana Foundation for Medical Care Handbook

b. Coded Drug Manual

c. Fee File

d. MMA Relative Value Schedule

SSI Project
Flow Chart


Error Cases to Field Review for QA to QC Adaptation
State Edit
SSI Sample (From Quality Assurance)
Claims Collection on All SSI Cases
Process Cases for Erroneous Payments Due to CP, Elig & TPL
Final Edit of QC Claims Process
Data Entry
Send to DHEW
Return to State Data Update
Non-error Cases to Processing
Determination of Dollars Lost Due to CP, Eligibility and TPL
Reports

(Exhibit B)

(Exhibit C)

MAO/ADC Project
Flow Chart


Selection of MAO & ADC Sample
QC Section: Case Review Eligibility Findings
Claims Section: Collection of Paid Claims for Sample
State Edit of Eligibility Findings
Process Cases for Erroneous Payments Due to CP, Elig. & TPL
Determination of Dollars Lost Due to CP, Elig., and TPL
Final State Edit of QC/ Claims Process
Data Entry
Reports
Case Sent to DHEW
Return to State, Data Update

e. Montana Provider Listing-Alpha/Numeric

f. Montana Procedure File with RVS Values

g. Microfilm Log

h. Microfilm Tapes

i. Adjustment Codes

3. The sample selection was developed on a case basis selection by sampling from the eligibility file rather than from the paid claims tape. During December a total of 204 cases were pulled for review for the months of April, May, and June, 1977. A total of 405 cases were pulled for the MAO sample for the six month project purposes. The entire sample of ADC cases, for the period 4-77 through 9-77, was used for project purposes as well as the entire Quality Assurance Sample, for that same period.

4. During December, staff developed the procedure for third party inquiry. Since the cases were retroactive, it was necessary to make contacts with recipients, insurance companies, and other potential third party sources. (Exhibits D, E and F were developed for inquiry concerning third party liability.) When possible the claims examiners made third party contacts by telephone.

5. Jared Davis, Recoveries Supervisor, developed a computer program to pull claims for the recipients in the sample cases. Claims were pulled by recipient number from the Dikewood paid claims tape. The original claims were then printed from microfilm on a reader-printer.

6. The staff collectively decided to review those cases in which the recipient died during the review month. This procedure shall be used for project duration.

(Exhibit D)

The Big Sky Country

# STATE OF MONTANA

## SOCIAL AND REHABILITATION SERVICES

P O BOX 4210
HELENA, MONTANA 59601

MONTANA

THOMAS L. JUDGE
GOVERNOR

PATRICK E. MELBY
DIRECTOR

Dear

We are presently conducting a Medicaid demonstration project and as part of this project it is necessary that we collect information regarding medical and/or accident insurance. To complete that information we need to ask the following questions:

I. Did you have medical and/or accident insurance during the month of _____, 1977?
Yes_____ No_____, If so, please give us the following information:

Name of policyholder_____
Insurance Co. name_____
Policy Number_____
Group/Membership number_____
Date coverage began_____
Date coverage terminated_____

2. Have you been in an accident in the past year?
Yes_____ No_____, If yes, please give us a detailed description of how the injury occurred, when and where. Use the reverse side of this letter.

Thank you for your cooperation. A stamped envelope is enclosed for your mailing convenience.

Claims Section
Program Integrity Bureau

(Exhibit E)

The Big Sky Country

# STATE OF MONTANA

## SOCIAL AND REHABILITATION SERVICES

P O BOX 4210
HELENA MONTANA 59601

MONTANA SRS

THOMAS L JUDGE
GOVERNOR
PATRICK E MELBY
DIRECTOR

Gentlemen:

We are conducting a demonstration project on Medicaid recipients and it is necessary that we verify all possible insurance coverage of those recipients. In this case it is necessary to verify whether or not the above-named has or had coverage and the names of individuals covered by this policy. Would you please indicate the type of coverage and effective date of such coverage.

Also, would you verify whether or not there are claims pending and/or paid with service dates during , 1977, for any individuals covered by this policy.

| Date of Service | Provider | Claim Amount | Date Submitted |
|---|---|---|---|

Your assistance in this matter is greatly appreciated.

Sincerely,

Claims Examiner
Program Integrity Bureau

KD/vt

Exhibit F

AUTHORIZATION TO RELEASE INFORMATION

NAME:_____

FILE:_____

I, the undersigned, authorize_____ to disclose information regarding my membership in_____, and any payments for services made in behalf of_____. And I expressly direct_____ to make such disclosures as may be requested to the Montana Social and Rehabilitation Services Division, it agents and representatives.

DATE:_____ SIGNATURE:_____

7. The Project administrative staff together with SRS legal staff made the decision for project duration that in the treatment of third party liability on the part of absent fathers (where a divorce decree stipulates his liability for the childrens' medical coverage) the father has the obligation to pay. In a case where the obligation is stipulated, those medical payments made will be coded in error.

8. A contract was completed with Jerry Smith, Computer Programmer, for completion of tasks 3, 4, 5, 6, and 7. A copy was forwarded to Washingtion, D.C.

9. The Claims Examiner began the claims examination process. Seventeen (17) cases for April, 1977, were completed in the universe. Claims are gathered for a period of seven (7) months including the review month. Those cases completed in December, 1977, had no claims in the period mentioned.

10. The Quality Control Supervisor and Project Director conducted field visits to Quality Control Reviewer offices for the purpose of field training.

11. The project staff began the process of obtaining a microfilm reader-printer for claims reading and printing. A reader-printer was borrowed from the Montana Department of Natural Resources for two months and steps were taken to obtain authorization to transfer funds from salary savings to equipment. A letter requesting authorization was sent to Mr. William C. Pembleton, Grants Officer, and a Justification for Purchase of Major Equipment was forwarded to the Montana State Department of Administration.

12. Two hundred twenty-five claims were processed for those ADC cases from April-September, 1977. Claims were reviewed, printed, and incorporated into the process.

13. A three months case goal completion projection was submitted to the Denver Regional Office.

January, 1978

1. When the first draft of a review schedule redesign, completed in December was found unworkable, a final redesign was completed during January, 1978. A review schedule redesign was developed to replace the proposed federal schedule because: a) the proposed schedule did not differentiate between the Quality Control Reviewer Section and the Claims Examiner Section. Quality Control Field Reviewers were doing the field eligibility review and Claims Examiners the Third Party-Claims Processing section. b) The proposed schedule was not designed for computer input, thus the redesign was formulated for data collection and coded for computer input.

The Review Schedule included a deductive method of arriving at a single indicator of claims paid in error. The revision also included a method to include types of assistance under item H. Through this method the computer data will distinquish between: a) Case only-ADC and SSI money payments, b) Cash nursing home - where SSI of #25.00 is the only income to the recipient, c) Cash personal care - SSI $25.00 payment only to a personal care home, d) Medically needy only - medical assistance to AFDC and SSI recipients. e) Medically needy nursing home - medical assistance only when the recipient has income such as Social Security, rental, or Veteran's

payments, f) Other (specify) - this item covers foster care, individuals in Montana Institutions, and any cases that do not belong in items 1-6. Instructions for review schedule completion were compiled for field distribution. (The review schedule, which was developed during January and was used throughout the project, is included as Exhibit G).

2. During January, tasks one and two of the Montana Work Plan, as proposed by Central Office, were completed and forwarded along with the monthly report.

3. The Research Specialist began the development of a computer program for extrapolating of data from the review schedule for reporting purposes.

4. David Selleck, Denver Regional Office, visited the project on January 17 and 18, 1978, for the purpose of monitoring claims processing activities.

5. Project Claims Review received 63 MAO sample cases from quality control eligibility review. (These cases have been selected since the project beginning and are cases for the months of April, May, June and July. (50 cases completed, 13 cases dropped.)

6. Cases completed and forwarded to Denver for Re-review during January, 1978:

AFDC.....12

MAO.....13 (cases dropped)

MAO..... 9 (Cases completed)

7. Claims were extrapolated from the paid claims tape from the MAO lists of cases and recipients. 432 claims were read and printed. This included the review months of April, May, June, and July, 1977, and claims printed from April through October, 1977.

(Exhibit G)

# MEDICAL QUALITY CONTROL REVIEW SCHEDULE

Review No. _____

| 1. Case Name: | 2. Address: | | | |
|---|---|---|---|---|
| 3. Case No. (S.S. No.): | 4. Service Period: | 5. Date Assigned: | 6. Date Completed: | 7. Reviewer: |

## I. IDENTIFYING INFORMATION

| A. State Code: | B. Local agency code: | C. Review No. *(in col. 6–8, indicate whether SSI, ADC or MAO).* | D. Date of most recent action: Yr. / Mo. |
|---|---|---|---|
| *(Card 1)* 30 (1 2) | (3 4 5) | (6 7 8 9 10 11) | (12 13) / (14 15) |

| E. Number of months between most recent action & service *(if concurrent with month service began, enter 00 ).* | F. Review Month: | G. Type of most recent action: (20) |
|---|---|---|
| (16 17) | (18 19) | ☐ 1. Approved application. ☐ 2. Redetermination. |

## II. RECIPIENT CHARACTERISTICS

**H. Type of Assistance:** *(check one)* (21)

- ☐ 1. Cash only
- ☐ 2. Cash Nursing Home.
- ☐ 3 Cash Personal Care
- ☐ 4. Medically Needy only.
- ☐ 5. Medically Needy Nursing Home.
- ☐ 6. Medically Needy Personal Care.
- ☐ 7. Other (specify) _____

**I. Basis for categorical relationship:** *(check one)* (22)

SSI RELATED:
- ☐ 1 Aged
- ☐ 2. Blind
- ☐ 3. Disabled

AFDC RELATED:
- ☐ 4. Death
- ☐ 5. Incapacity
- ☐ 6 Unemployed Father
- ☐ 7. Continued Absence

NEEDY INDIVIDUAL UNDER 21:
- ☐ 8. Foster Care
- ☐ 9. Other

**J. Medicaid eligibility coverage requirement used by agency:** *(Code)* (23 24)

**K. Number of persons in household:** (25 26)

**L. Number of persons in Medicaid Assistance group:** (27 28)

**M. Is the claim for service provided during period of retroactive coverage?** ☐ 1. Yes ☐ 2. No (29)

**N. Did the case record show presence of any of the following elements at the time service was provided?** (30 31 32 33)

| | Earned Income | RSDI Benefits | Other Government Program Benefits | Other Income |
|---|---|---|---|---|
| (a) Income: | ☐ 1. Yes ☐ 2. No | ☐ 1. Yes ☐ 2. No | ☐ 1. Yes ☐ 2. No | ☐ 1. Yes ☐ 2. No |
| | Real Property *(Home & Other)* | Life Insurance | Medical Insurance | Personal and Liquid Assets |
| (b) Resources: | ☐ 1. Yes ☐ 2. No | ☐ 1 Yes ☐ 2. No | ☐ 1. Yes ☐ 2 No | ☐ 1 Yes ☐ 2 No |

(Exhibit G)

Medical Quality Control Review Schedule  Review No. _____

## III. REVIEW FINDINGS

O Disposition of review *(check one)* 38

☐ 1 Review completed

If code 1 is checked, complete the remainder of Section III below. If any other code is checked, no further entry is required.

☐ 2. Moved out of State since service provided
☐ 3 Unwilling to give information
☐ 4. Died since service provided
☐ 5. Unable to locate.
☐ 6. Other *(explain)* _____

☐ 7. Not reviewed - listed in error

P. Summary findings *(check one)* "Spend-Down" Error Only 39

☐ 1 Eligible ☐ 2. Ineligible for part or all of service period. ☐ 3. Recipient liability understated. ☐ 4. Recipient liability overstated.

☒ 5. Eligible with ineligible members

Q. From Section P, if item 2, 3 or 4 checked, enter the number of errors: or 5 40

R. For eligible findings, Medicaid eligibility coverage requirement used by reviewer 41 42

If the recipient is eligible, no further entries are required in the eligibility section.

S. Primary error resulting in ineligibility or payment status occurred: 43

☐ 1 Before most recent action. ☐ 2. At time of most recent action. ☐ 3. After most recent action.

T. Does there appear to be willful misrepresentation of facts? *(check one)* 44

☐ 1. Yes ☐ 2. No ☐ 3. Not applicable.

U. Description of Error(s)

| | Element | Nature | Type | Error Finding |
|---|---|---|---|---|
| Error 1 | 45 46 47 | 48 49 | 50 51 | 52 |
| Error 2 | 53 54 55 | 56 57 | 58 59 | 60 |
| Error 3 | 61 62 63 | 64 65 | 66 67 | 68 |

80

## IV. EXPLANATION OF ELIGIBILITY ERRORS

| (1) Elements | (2) Nature of Error | (3) State Manual Citation |
|---|---|---|
| | | |

## IV. EXPLANATION OF ELIGIBILITY ERRORS (B)

*(Card 2 – Duplicate columns 1–11 from Card 1)*

V. Total dollar amount of paid claims for case for the review period: [ ][ ][ ][ ][ ] 12 13 14 15 16

W. Dollar amount of claims paid in error: [ ][ ][ ][ ][ ] 17 18 19 20 21

X. Number of persons in case receiving service: [ ][ ] 22 23

Y. Number of ineligible persons receiving services: [ ][ ] 24 25

## V. THIRD–PARTY LIABILITY FINDINGS

A. Was a third-party resource available to recipient during the review period? [ ] 26

☐ 1. Yes ☐ 2. No *(If "no", proceed to Section VI)*

B. Was health insurance available to recipient? *(check one)* [ ] 27

☐ 1. No

☐ 2 Yes, but not known.

☐ 3 Known, but not utilized properly.

☐ 4 Known, and utilized properly

C. Was a liable absent father available to recipient during the review period? *(check one)* [ ] 28

☐ 1. No

☐ 2. Yes, but not known.

☐ 3. Known, but not utilized properly.

☐ 4. Known, and utilized properly.

D. If an accident occurred, it was: *(check one)* [ ] 29

☐ 1. Not indicated on claim.

☐ 2. Indicated on claim, but not pended for follow-up.

☐ 3 Indicated on claim, and pended for follow-up.

E. Description of error(s):

| | Element | Nature | Type | Uncollected Dollar Amount |
|---|---|---|---|---|
| Error 1 | [ ][ ][ ] 30 31 32 | [ ][ ] 33 34 | [ ][ ] 35 36 | [ ][ ][ ][ ][ ] 37 38 39 40 41 |
| Error 2 | [ ][ ][ ] 42 43 44 | [ ][ ] 45 46 | [ ][ ] 47 48 | [ ][ ][ ][ ][ ] 49 50 51 52 53 |
| Error 3 | [ ][ ][ ] 54 55 56 | [ ][ ] 57 58 | [ ][ ] 59 60 | [ ][ ][ ][ ][ ] 61 62 63 64 65 |

F. Estimated total uncollected third-party liability: [ ][ ][ ][ ][ ] 66 67 68 69 70

## VI. ERRONEOUS PAYMENTS FINDINGS

*(Card 3 – Duplicate columns 1–11 from Card 1)*

A. Total number of claims paid: [ ][ ][ ] 12 13 14

Total number of claims paid in error. [ ][ ][ ][ ][ ] 15 16 17 18 19

C. Description of payment errors:

| Claims with error(s) | Element | Nature | Type | Dollar Amount of Error |
|---|---|---|---|---|
| 1 | [ ][ ][ ] 20 21 22 | [ ][ ] 23 24 | [ ][ ] 25 26 | [ ][ ][ ][ ][ ] 27 28 29 30 31 |
| 2 | [ ][ ][ ] 32 33 34 | [ ][ ] 35 36 | [ ][ ] 37 38 | [ ][ ][ ][ ][ ] 39 40 41 42 43 |
| 3 | [ ][ ][ ] 44 45 46 | [ ][ ] 47 48 | [ ][ ] 49 50 | [ ][ ][ ][ ][ ] 51 52 53 54 55 |

D. Net effect (dollar amount) of errors: [ ][ ][ ][ ][ ] 56 57 58 59 60

## VII. TOTAL NET EFFECT OF CLAIMS PAID IN ERROR

A. Total amount of dollars paid in error: [ ][ ][ ][ ][ ][ ] 61 62 63 64 65 66

3
80

8. The Project Director received verbal approval from Larry Knape, Project Officer regarding transfer of funds for purchase of a reader-printer.

9. The Project Director received verbal approval that SSI Quality Assurance records would be forthcoming for project review in early February.

10. Doug Egan, Statistics and Research Chief, was contacted regarding the status of the contract with Jerry Smith for completion of tasks 3, 4, 5, 6, and 7. Mr. Egan reported that Mr. Smith is working on the eligibility file in order to complete documentation of the tasks outlined. He is currently writing a program for the retroactive eligibles (task 5) and is working on the creation of a module for running ADC, SSI, and MAO against the claims tape, rather than the current procedure of separate runs.

11. During January the Claims Examination Section completed step-by-step process of Third Party Liability-Claims Processing functions which included a detailed explanation of project procedures followed for case completion. (Exhibit H is the outline of this process).

February, 1978

February, for project purposes, can be defined as problem month. The project staff progress was hampered due to coding errors with temporary identification numbers. The fiscal intermediary changed computers and SRS Data Processing had problems adapting the new Burroughs paid claims tape to the SRS system. (The problems are further explained under the problems section of this report).

# Case Completion

I. Case received from Control Eligibility Review:
   A. Check third party liability.
      a. Insurance.
      b. Responsible parent (divorce decree states responsibility for medical).
   B. Send insurance inquiry to recipient.
   C. Send inquiry to responsible parent.
   D. Send inquiry to insurance company.

II. Pull printout of services from paid claims tape, print claims and match with cases.

III. Claims Review:
   A. Completeness of claim - Is all pertinent information on the claim: DOB, date of service, ID#, charges, procedure codes, signature of claimant, etc.
   B. Eligibility Status of Provider - Is claim submitted under proper provider number as listed in alpha/numeric provider listing.
   C. Compliance of claim with Policy Regulations:
      a. Service must be one covered by program.
      b. Service must be compatible with the diagnosis.
      c. Claim for prior authorized services must comply with services authorized.
   D. Reasonableness of Payments:
      a. Payment must not be higher than allowed by Medicaid.
   E. Duplication of Payment:
      a. Comparison of claims to determine service has not been billed and paid twice.

IV. Type of Service:
   A. Physician Claim:
      a. Compare diagnosis with procedures.
      b. Check to see if the service was related to an accident or illness.
      c. Compute the cost of the procedure.
   B. Inpatient Hospital:
      a. Payment within the allowable percentage.
      b. Should correspond to physician claim.
      c. Claim should not include charge for day of admittance as well as day of discharge.
      d. Check to see that there is no charge for surgery when surgery was cancelled
      e. Check for charges for Luxury items.
      f. Check for excess time between admission and surgery dates.
      g. Check for length of stay to make certain stay does not exceed length of stay guidelines (this should be caught peer review level).
   C. Long Term Care:
      a. Was the patient's admission certified by the Foundation.
      b. Was the level of care billed at the correct rate.
      c. Were personal resources correctly deducted.
   D. Pharmacy Service:
      a. Do the drug name and number correspond.
      b. Was the amount paid properly computed.
      c. Was the refill too early for the previous quantity to be consumed.
      d. Was the drug an allowable drug.
      e. Were there repeat prescriptions by the same or different physicians.
      f. Is there a disagreement between the drug and diagnostic code.

E. Other Services:
   a. Do mental health claims correspond with signed agreements.
   b. Were dental services paid at the correct rates and were the procedure codes correct for the services extended.
   c. Do the laboratory services correspond to the physician claim.
   d. Do the transportation claims correspond to the established rate.
   e. Eye care claims - do procedure codes correspond with service amount paid according to the fee schedule.
   f. Home health services - are they provided in accordance with the signed agreements.
   g. Therapy claims - do they correspond with the fee schedule.
   h. Private duty nurse - has there been prior authorization and was this paid at the established rate.
   i. Audiologist & speech claims - were they paid in accordance with the established rates.
   j. Podiatry services - are proper procedure codes listed and paid according to the established fees.
   k. Family planning claims - were they processed according to the physician claim and drug claims.
   l. Supplies - were they paid in accordance with the established supply list.
   m. Prosthetic devices - these are paid without prior authorization for items under $50.00. Items over $50.00 need prior authorization with a physician's prescription attached to the claim (orthopedic shoes are not provided).
   n. Cosmetic type devices (watch for these) such as wigs, artificial breasts, etc., are not provided.

V. Tally Sheet Completion:
During the processes of one through four, claims information is listed on the tally sheet for each recipient who received services.

VI. Review Schedule Completion:
The tally sheet information is transferred to the appropriate sections of the review schedule.

VII. Final Case Completion:
The completed review schedule, tally sheets, claims print-outs, and eligibility review worksheets are attached to complete the eligibility/third party liability/claims processing review.

1. During February, the project received confirmation that the reader-printer had been approved by the Department of Administration and that the machine would be delivered in six months.

2. During February, Ann Murray, Linda Fraser, and Blanche Goerhing met with Geraldine Manzo, Quality Assurance in Billings, Montana, and went over the SSI cases. At this time, Ms. Manzo went through the coding manual with project personnel and a system was developed to interface SSI error codes with the Quality Control error codes.

3. The claims examiners developed an emergency method for claims examination completion, necessitated by delays in adapting to the format of the new paid claims tapes. Claims for cases were pulled from the computer scope for case completion.

4. Max Buffington called regarding the April Implementation Meetings in New Orleans, Denver, Washington, D.C. He reported that financial arrangements were formulated for the Project Director's attendance at these meetings to give a brief presentation on Montana's experience with the process.

5. Project staff began arrangements for travel to the Denver Regional Implementation meeting. Plans were for Ann Murray, Quality Control Supervisor; Jared Davis, Claims Examination Supervisor; Bob Morgan, Research Specialist; and Linda Fraser, Project Director, to attend the meeting.

6. During February 1978, 100 cases were completed and sent to DHEW for re-review. During February 1978, thirty-six eligibility reviews were completed and assigned to claims processing.

During this month form letters were developed to notify counties of Medicaid errors in eligibility, erroneous payments and

third party liability. A referral form was developed to refer errors to the Recoveries Unit and a concurrence letter was developed to be sent to the Dikewood Corporation. (These form letters are included as Exhibits I, J, K, and L.)

March, 1978

1. Project staff met with Richard Morey and Rick Johnson, Control Analysis Corporation, on March 2 and 3, 1978, regarding the evaluation of the project. Dr. Morey is compiling a list of activities for consideration for testing during the lag time between project activities completion and implementation.

2. Project staff: Ann Murray, Jared Davis, Bob Morgan and Linda Fraser attended the HCFA Technical Assistance Training Meeting in Denver, Colorado, on March 13, 14, and 15, 1978.

3. Project Director, Linda Fraser, attended the HCFA Training Meeting in New Orleans on March 7, 8, and 9th, and the Washington, D.C. meeting on March 20, 21, and 22nd. A brief presentation of the Montana experience in implementation was presented at each of the three meetings.

4. Project Supervisors and Director began discussing plans for further training of field staff prior to implementation. David Selleck was contacted for technical assistance for the training session and the first week of May was tentatively set for the meetings.

5. Staff began SSI ineligibles tests for MAO eligibility. In two cases, lump sum payments were made after the sample month, thus were MAO eligible. In one case, a lump sum was received during the sample month, two cases were payment amount errors and one case is

(Exhibit I)

The Big Sky Country

STATE OF MONTANA

SOCIAL AND REHABILITATION SERVICES

P.O. BOX 4210
HELENA, MONTANA 59601

MONTANA

THOMAS L. JUDGE
GOVERNOR

PATRICK E. MELBY
DIRECTOR

ECONOMIC ASSISTANCE
JACK R. CARLSON
ADMINISTRATOR

Case Name_____ Review#_____ Date_____

Case Number_____ Category_____

County_____ Q.C. Reviewer_____

This case was reviewed by Medicaid Quality Control and was found to have a:

a. Third party liability error $_____ (Flag TAD for TPL: _____yes _____no)

b. Erroneous payment error $_____

$_____ Total amount of dollars paid in error for the month of review as found through claims examination.

This letter is for your reference and unless item (a) is checked 'yes,' no action is required as referral has been made to the recoveries unit.

(Exhibit J)

The Big Sky Country

# STATE OF MONTANA
## SOCIAL AND REHABILITATION SERVICES

P.O. BOX 4210
HELENA, MONTANA 59601

MONTANA

THOMAS L. JUDGE
GOVERNOR

PATRICK E. MELBY
DIRECTOR

ECONOMIC ASSISTANCE
JACK R. CARLSON
ADMINISTRATOR

Case Name_____ Review #_____ Date_____

Case Number_____ Category_____

County_____ Q.C. Reviewer_____

You were previously notified by a QC-5A the above case was found totally ineligible as of the review date.

We are now reporting the total net effect of claims paid in error due to ineligibility for the review period_____ _____.

$_____ Total amount of dollars paid in error for the month of review as found through claims examination.

This letter for your reference and requires no action, as referral has been made to the Recoveries Unit.

(Exhibit K)

The Big Sky Country

# STATE OF MONTANA
## SOCIAL AND REHABILITATION SERVICES

P.O. BOX 4210
HELENA, MONTANA 59601

MONTANA SRS

THOMAS L. JUDGE
GOVERNOR
PATRICK E. MELBY
DIRECTOR

ECONOMIC ASSISTANCE
JACK R. CARLSON
ADMINISTRATOR

TO: Recoveries Unit

FROM: Medicaid Quality Control

RE: Referral for possible collection of misspent $

| | |
|---|---|
| Case Name_____ | Review #_____ Date_____ |
| Case Number_____ | Category_____ |
| County_____ | Q.C. Reviewer_____ |

This case was reviewed for service date_____.
The following error/errors were cited:

Third Party Liability_____

Erroneous Claims Paid_____

Eligibility Error_____

(Exhibit L)

The Big Sky Country

# STATE OF MONTANA

## SOCIAL AND REHABILITATION SERVICES

P.O. BOX 4210
HELENA, MONTANA 59601

MONTANA SRS

THOMAS L. JUDGE
GOVERNOR

PATRICK E. MELBY
DIRECTOR

ECONOMIC ASSISTANCE
JACK R. CARLSON
ADMINISTRATOR

TO: Dikewood Corporation

FROM: Medicaid Quality Control

Subject: Verification of Claims Processing Error Condition

Our review of this claim shows that it contains conditions which may be regarded as Quality Control errors. Would you please review this claim and verify our findings? If you disagree with our findings please respond within two (2) weeks. If your reply is not received within two (2) weeks, we will consider our findings as final.

Case No.:_____ Case Name:_____

Claim ICN:_____ Service Type:_____

Description of error:

currently in review status. (The case, a "holding out" case is currently being tested for MAO, taking into consideration the ineligible spouse's income as deemed and the incurment.)

6. One hundred and seventy-three (173) AFDC, MAO, and SSI were completed during March, 1978, and forwarded for review.

7. Ninety-nine (99) cases were completed by field eligibility review staff and forwarded for claims processing and third party reivew.

8. Project staff began formulating plans for a consultant contract to look at the Dikewood System of Edits.

April, 1978

1. On 4-7-78, Larry Knape, Evaluations Branch, called to report that the Amendment for the Control Analysis Corporation Evaluation was signed.

2. On 4-11-78, Ann Murray and Linda Fraser attended a meeting in Billings, Montana, with Geraldine Manzo, Quality Assurance, North Dakota Quality Control Director, and David Selleck, Denver Regional Office.

3. Project staff formulated plans for May 1st through 4th for Quality Control training. Requested remarks from Jim McCabe, Program Integrity Bureau Chief, and Mr. Melby, SRS Director. Medically Needy Program requirements were also requested of Betty Todd, Medicaid Program.

4. Staff met with Franklin Smoyer on April 14th and April 21st concerning contract for Analysis of Fiscal Intermediary, Dikewood Corporation. Plans are to audit the manual and automated edits, check the procedures for preventing duplicate payments and

evaluating the interface of the Dikewood System and the quality control claims examination procedure.

5. Began draft of Control Analysis Corporation Contract. The contract was approved by SRS Legal Unit on 4-26-78.

6. During the week of the 17th, the Claims Examiners completed a special assignment for the Director's Office, a survey corrective action procedure.

7. A letter was sent to Larry Knape, Evaluations Branch, concerning Project plans to decrease from 300 MAO to 175 for implementation in the period April, 1978, through September, 1978, and the changes in the Control Analysis evaluation due to implementation of the MQC Process.

8. Richard Morey, Control Analysis Corporation, arrived on 4-24-78, and worked on the Project Evaluation on 4-25-78, 4-26-78, and 4-27-78. Attached is a copy of his report of findings through 3-31-78.

9. One hundred and forty-five (145) cases were completed by field eligibility review, and forwarded for CP and TPL Review.

One hundred and seventy-one (171) cases were completed and forwarded to Denver Regional Office for re-review.

May, 1978

1. Bob Morgan completed Task #3, of the Federal Work Plan Proposal, on May 23, 1978. This report covered the period April-September, 1977, and shows the caseload universes and program-wide expenditures by strata for Montana Medicaid.

2. On May 1, 2, and 3, 1978 a training session was held in Helena for Medicaid Quality Control staff. David Selleck, DHEW Regional

office conducted training on the changes in MQC with nationwide implementation in April, 1978. The Project Claims Examiners gave a detailed presentation of the step-by-step process of Claims Processing/Third Party Liabilities activities of the project.

3. Richard Morey and Rick Johnson of Control Analysis Corporation worked in our Helena office on Project Evaluation on May 17th and 18th. The final draft of the Contract was signed on May 22, 1978, and forwarded to your office on that date.

4. On May 26, 1978, the Contract was completed for final draft for Dikewood Corporation/Montana Foundation for Medical Care evaluation and Claims Processing/Third Party Liability interface with the Dikewood Claims Payment System. Franklin Smoyer and Company will do this analysis.

5. During May, 1978, 124 cases were completed. There were 22 ADC, 30 SSI and 72 MN cases completed during the month. There were 144 cases yet to complete to meet the six month project goal.

6. To date, of the 629 cases completed, there were 68 case drops, 396 cases with claims and 65 total cases with errors.

7. After completion of May cases, the error rate increased from 3.9% to 8.3%. The error rate in SSI increased from 0.7% to 3.9%. The major reason for this substantial increase was that cases that appeared to have error problems and/or many claims were set aside and completed during May. These cases were set aside as prior cases were completed from the computer scope when few claims were in evidence in the case.

8. On May 26, 1978, a letter was written to Steve Hudack requesting that authorization be given to the Project for an

extention for Control Analysis Corporation and Franklin Smoyer to submit all evaluation reports on or before November 30, 1978, in order to allow ample time to evaluate final results through September 30, 1978.

9. During May, 1978, the Claims Examiners completed a detailed time-motion study for the processes of TPL examination and CP. (This time study is included as Exhibit M)

June, 1978

1. An outline was designed for reference to write and compile a Montana Medicaid Quality Control Procedures Manual. The California Procedures Manual was used as a guideline. This manual will be compiled by Project staff and Quality Control staff.

2. Task 4, the Correction Factor and Task # 6, Claims Payment Distribution were completed and forwarded to Central Office during June, 1978.

3. Robert Morgan, Research Specialist, Computed the error rate of 675 cases completed. The error rate was 8.953, 22.7% in ADC, 11,8% in SSI, and 2.4% in MAO.

4. Larry Knape, Evaluations Branch, called to report that the final project meeting will be in San Francisco on July 11 and 12, 1978.

5. Position Justifications were prepared for the Director's Office for the four positions requested for the continuance of the process when Project ends on 9-30-78.

6. A team of quality control eligibility field staff conducted in-depth eligibilty reviews in approximately 60 cases in both Lewis & Clark and Yellowstone Counties. Plans are to conduct more of these types of reviews over the next two to three months.

Claims Examiners Time Study:

Ten cases were chosen at random to comprise the study. Chosen were five MAO, three ADC, and two SSI cases. Four separate tasks were timed by each examiner. These tasks included the following:

1) Third party liability section - which includes review of eligibility work sheets, letters written to insurance companies and, if necessary, release forms requested from the recipient.

2) Pull Claims - Claims are printed from Dikewood microfilm on the reader-printer. Film numbers are taken from paid claims print-out.

3) Tally Sheet - Identification information is entered as is claim line items. Payment information is checked among claims, payment schedules, and paid claim printouts. Information is then totalled for transfer to the review schedule.

4) Review Schedule - Edit reviewers entries, transfer information from tally sheet. Eligibility errors, third party information and claims processing errors entered and totalled.

Results of the time study are entered on the enclosed chart. All times are recorded in minutes.

(Exhibit M)

# CLAIMS EXAMINERS
# TIME STUDY

| TASK | | THIRD PARTY | | | | PULL CLAIMS | | | | TALLY SHEET | | | | REV. SCHEDULE | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CASE NO. | # of claims | WORKER 1 TIME | WORKER 2 TIME | WORKER 3 TIME | CASE AVG. TIME | WORKER 1 TIME | WORKER 2 TIME | WORKER 3 TIME | CASE AVG. TIME | WORKER 1 TIME | WORKER 2 TIME | WORKER 3 TIME | CASE AVG. TIME | WORKER 1 TIME | WORKER 2 TIME | WORKER 3 TIME | CASE AVG TIME | WORKER 1 CASE COMPLETION TIME | WORKER 2 CASE COMPLETION TIME | WORKER 3 CASE COMPLETION TIME | AVG. CASE COMPLETION TIME |
| ADC 109 | 3 | 12 | 10 | 13 | 11.7 | 14 | 16 | 11 | 13.7 | 10 | 15 | 16 | 13.7 | 5 | 5 | 5 | 5 | 41 | 46 | 45 | 44 |
| ADC 166 | 4 | 6 | 6 | 10 | 7.3 | 15 | 18 | 17 | 16.7 | 27 | 23 | 25 | 25 | 3 | 4 | 5 | 4 | 51 | 57 | 51 | 53 |
| ADC 225 | 8 | 8 | 10 | 12 | 10 | 30 | 30 | 25 | 28.3 | 45 | 16 | 42 | 44.3 | 5 | 5 | 5 | 5 | 88 | 91 | 84 | 87.7 |
| WORKER AVG. (ADC) | | 11.3 | 11.3 | 11.7 | | 19.7 | 21.3 | 17.7 | | 27.3 | 28 | 27.7 | | 4.3 | 4.7 | 5 | | 60 | 64.7 | 60 | |
| MAØ049 | 3 | 5 | 5 | 4 | 4.7 | 10 | 15 | 12 | 12.3 | 30 | 25 | 34 | 29.7 | 7 | 6 | 5 | 6 | 52 | 51 | 55 | 52.7 |
| MAØ130 | 1 | 5 | 4 | 3 | 4 | 20 | 17 | 15 | 17.3 | 10 | 9 | 10 | 9.7 | 7 | 8 | 9 | 8 | 42 | 38 | 37 | 39 |
| MAØ 211 | 2 | 5 | 4 | 7 | 5.3 | 10 | 16 | 12 | 12.7 | 20 | 12 | 15 | 15.7 | 6 | 5 | 7 | 6 | 41 | 37 | 41 | 39.7 |
| MAØ 292 | 2 | 3 | 3 | 8 | 4.7 | 5 | 8 | 10 | 7.7 | 17 | 15 | 15 | 15.7 | 5 | 4 | 7 | 5.3 | 30 | 30 | 40 | 33.3 |
| MAØ 373 | 5 | 2 | 3 | 5 | 3.3 | 10 | 12 | 10 | 10.7 | 55 | 45 | 50 | 50 | 4 | 5 | 8 | 5.7 | 71 | 65 | 73 | 69.7 |
| WORKER AVG. (MAØ) | | 4 | 3.8 | 5.4 | | 11 | 13.6 | 11.8 | | 26.4 | 21.2 | 25.2 | | 5.8 | 5.6 | 7.2 | | 47.2 | 41.2 | 49.2 | |
| SSI 013 | 10 | 30 | 30 | 25 | 28.3 | 60 | 15 | 50 | 51.7 | 10 | 50 | 45 | 45 | 10 | 8 | 10 | 9.3 | 140 | 133 | 130 | 134.3 |
| SSI 070 | 1 | 5 | 5 | 8 | 6 | 6 | 7 | 7 | 6.7 | 7 | 5 | 6 | 6 | 8 | 10 | 7 | 8.3 | 26 | 27 | 28 | 27 |
| WORKER AVG. (SSI) | | 17.5 | 17.5 | 16.5 | | 33 | 26 | 28.5 | | 23.5 | 27.5 | 25.5 | | 9 | 9 | 8.5 | | 83 | 80 | 79 | |
| | | | | | | | | | | | | | | | | | | | | | |
| WORKER AVG. (ALL STRATA) | | 8.1 | 8 | 9.5 | | 18 | 18.4 | 16.9 | | 26.1 | 24.5 | 25.8 | | 6 | 6 | 6.8 | | 58.2 | 57.5 | 58.4 | |

7. The sample plan was completed and forwarded to the Washington, D.C. and Denver offices during this week.

8. The first report from Control Analysis Corporation was received. This report included interim progress and methodology for use of recipient profiles.

July, 1978

1. A Corrective Action Report was completed by Robert Morgan during the month of July, 1978.

2. Project staff worked on the completion of all 705 project cases. Approximately 695 cases were completed by the end of July, 1978.

3. Robert Morgan and Linda Fraser attended the project meeting in San Francisco on July 11 and 12, 1978, for the purposes of arriving at an outline for the final report.

4. Task #7 was completed and forwarded to the Central Office during this month.

5. Project staff and State staff worked on the Montana Medicaid Quality Control Procedures Manual during this month.

August, 1978

1. During August, all project cases were completed along with the eleven reports included in the reporting manual.

2. The Medicaid Quality Control Montana Procedures Manual was completed during this month.

3. Project staff began researching the implementation procedures to prepare for claims processing and third party liability case completions during the month of October 1978. April cases will be ready for claims processing/third party liability reviews in October 1978.

E. Problems

The Medicaid Quality Control Project, as with all new bureaucratic processes, was not without problems. Some of the problems encountered were due to "people type" errors through carelessness, while others were due to incorrect or improper decision making. The third type of problems encountered were those that were unforeseen and which staff could not control.

The impact on the project of the problems encountered are impossible to assess in order of importance. The following are problems that caused delay and/or errors in the development of the project process:

1. The first problems encountered were of a physical nature. Although the project began October 1, 1977, staff was not on board until November 21, 1977, due to recruiting and hiring processes. Because of overcrowded conditions in the SRS building in Helena, office space was finally obtained in a conference room in mid-November. Office equipment deliveries were slow, making it necessary to temporarily borrow such items as chairs, typewriters, etc.

2. While field review had an established procedure for the programs of Aid to Dependent Children and Medical Assistance Only, there were problems in reviewing Aid to Dependent Children for Medicaid eligibility. Due to inherent differences in the programs of ADC and MAO, many arbitrary decisions were made early in the project. The following are problems encountered in eligibility review and treatment of such problems.

a. In those cases of ADC where the case was found totally ineligible as of the review month due to excess earnings, the

cases were tested for the medical assistance four months extension.

b. In cases of ADC where all household members were found totally ineligible due to mandatory WIN registration requirements, the cases were treated as ineligible. These cases were tested for MAO with implementation of the process.

c. For ADC supplemental cases, (those cases in which the first check was issued by county warrant) the first month in which the case was opened was examined for claims. The county issued check may cover a period of a partial month, a partial month and the month following, or may cover two complete months. For example, a recipient may apply on May 1, be approved on May 28, and a check may be issued covering May and June. (In this case, May would be the month reviewed for eligibility.) A check, on the other hand, may cover a period of May 13-June 30 provided the application was taken on May 13. (In this case, the eligibility review would be June 1, the first complete month based on May criteria.) The claims were examined for May, the month in which the case was first opened. (This problem was totally alleviated for implementation as Montana no longer pulls an ADC supplemental sample.)

d. Since the sample pull included some cases of more than one foster child listed in a household and other cases where one child was listed, yet a sibling also resided in the foster home, the problem was discussed with Mr. Selleck, Denver HEW Office. Instructions were to review all children where more than one foster care child from the same family was included in

the payment and placed under a court order on a total case basis.

3. With SSI testing for MAO, several problems were encountered with the interface of Quality Assurance and Quality Control. Quality Assurance reviews are conducted on a quarterly basis. For example, a lump sum received in May might create ineligibility for an entire quarter. These cases were tested for MAO eligibility, and for Medicaid purposes were found eligible due to the recipient reporting time frame. There were also problems in interfacing the SSI coding with the MQC coding for citation of errors. It was also necessary to acquaint staff with the deeming procedures used by SSI to test Medicaid eligibility in deeming cases.

4. For project purposes, after a meeting with SRS legal staff, a decision was made to code errors in third party where the absent father had a legal obligation to pay medical for the children. In keeping with the Title IV rules, when the father was absent but there was no legal separation or divorce the medical for both the mother and children was cited in error due to his legal liability. This decision artifically inflated the TPL errors.

5. On Halloween, 1977, the fiscal intermediary, Dikewood Corporation, switched from a Xerox to Burroughs computer. This switch created many delays. Several weeks were spent by Data Processing staff developing a program to read the changed paid claims tape. The emergency alternative, which was to use the computer scope, created other problems in that not all claims were shown on the scope due to payments at the end of the month.

6. Early in the development of the process, it was found that there was not a reader-printer in SRS. A reader-printer was borrowed in the interim while awaiting approval to transfer funds from salary savings to equipment to purchase the machine. (A reader-printer is necessary for printing of hard copy claims for completion of the process.)

7. Due to a coding error of transposing case numbers and recipient numbers the first group of ADC cases were completed in error. The problem resulted in additional claims for household members not being pulled. The cases were recalled from the re-review for correction when the problem was identified.

8. Another problem encountered was in cases where recipients had both temporary identification and the permanent social security number identification. For a period of time, we did not pull any of the temporary identification number claims because of incorrect coding of these numbers. When the problem was identified claims were pulled under both numbers.

9. It was necessary to develop a review schedule which was workable for the process and which would collect the data necessary for reporting. The original re-design was not usable, thus a second draft was finally completed in January 1978.

10. The most perplexing problem encountered by the project was the advent of nationwide implementation. Prior to April 1978, the pilot test developed with little or no guidelines. While guidelines were in the developmental stages in Montana and California, the Federal Government was developing volumes of guidelines to implement the process. Procedures recently devised through the pilot test

were given new interpretations. Implementation made it necessary for staff to forget project methodology and begin studying the new material and guidelines for nationwide implementation.

F. Unresolved Federal Issues

Through the Montana experience with the pilot test, and with implementation development, there are a number of issues of a federal nature which may create future problems with the Medicaid Quality Control System.

In some states, sample integrity may become an issue due to the procedure of immediate eligibility re-review followed by a CP/TPL re-review several months later.

Based upon the diversity of CP procedures and TPL treatment from state-to-state, actual error citation may be inconsistent. The procedures for error citation probably need further refinement.

Due to differences in Medicaid Quality Control and Quality Assurance methodology for review, the reviews of Medicaid should be further refined.

III. FINDINGS:

The following includes the eleven Medicaid Quality Control reports which includes 15 tables. Also, included is the Corrective Action Report, completed by Robert Morgan, Research Specialist for the Project.

# TABLE I A
## MEDICAID QUALITY CONTROL
## STATISTICAL SUMMARY

STATE Montana REPORTING PERIOD 4-77 TO 9-77

| | | STRATUM | | | TOTAL |
|---|---|---|---|---|---|
| | | MAO | AFDC | SSI | |
| I | AVERAGE MONTHLY MEDICAID CASELOAD | 5285 | 6124 | 7489 | 18,898 |
| II | TOTAL MEDICAID PAYMENTS MADE DURING THE REPORTING PERIOD | 11,139,553 | 3,886,878 | 7,161,484 | 22,187,914 |
| III | NUMBER OF CASES SELECTED FOR THE REPORTING PERIOD | 405 | 177 | 123 | 705 |
| IV | NUMBER OF REVIEWS COMPLETED DURING THE REPORTING PERIOD | 351 | 158 | 122 | 631 |
| V | TOTAL NUMBER OF SAMPLE CASES FOR WHICH REVIEWS HAVE NOT BEEN COMPLETED | (54) | (19) | (1) | (74) |
| | A. LISTED IN ERROR | 45 | 6 | 1 | 52 |
| | B. MOVED OUT OF STATE SINCE REVIEW MONTH | 4 | 10 | Ø | 14 |
| | C. UNWILLING TO GIVE INFORMATION | 2 | Ø | Ø | 2 |
| | D. COULD NOT BE LOCATED | Ø | 1 | Ø | 1 |
| | E. OTHER REASONS | 3 | 2 | Ø | 5 |
| VI | NUMBER OF COMPLETED REVIEWS HAVING CLAIMS | 284 | 104 | 70 | 458 |
| VII | NUMBER OF CLAIMS PROCESSED FOR SAMPLE CASES | 754 | 355 | 178 | 1287 |
| VIII | DOLLAR PAYMENTS FOR ALL SAMPLE CASES REVIEWED | 104,378 | 14,175 | 9,589 | 128,142 |

# TABLE I B

## MEDICAID QUALITY CONTROL

## NUMBER OF CASES AND AMOUNT OF ERROR BY ERROR CLASSISFICATION
(PAGE 1 OF 2)

STATE Montana REPORTING PERIOD 4-77 TO 9-77

| | | STRATUM | | | TOTAL |
|---|---|---|---|---|---|
| | | MAO | AFDC | SSI | PERCENT ONLY |
| I NUMBER OF CASES BY ERROR CLASSIFICATION | | | | | |
| A. CASES HAVING ONE OR MORE ERRORS | (1) # | 75 | 28 | 9 | |
| | (2) % | 21.37% | 17.72% | 7.38% | 17.75% |
| B. INELIGIBLE CASES | (1) # | 28 | 6 | 7 | |
| | (2) % | 7.98% | 3.80% | 5.74% | 6.50% |
| C. ELIGIBLE WITH INELIGIBLE MEMBERS | (1) # | 6 | 5 | Ø | |
| | (2) % | 0% | 3.16% | 0% | 0.79% |
| D. LIABILITY UNDERSTATED ERROR ONLY | (1) # | 17 | | | |
| | (2) % | 4.84% | NA | NA | 2.69% |
| E. LIABILITY OVERSTATED ERROR ONLY | (1) # | 4 | | | |
| | (2) % | 1.14% | NA | NA | .63% |
| F. LIABILITY UNDERSTATED ERROR WITH INELIGIBLE MEMBERS | (1) # | Ø | | | |
| | (2) % | 0% | NA | NA | 0% |
| G. LIABILITY OVERSTATED ERROR WITH INELIGIBLE MEMBERS | (1) # | Ø | | | |
| | (2) % | 0% | NA | NA | 0% |
| H. CLAIMS PROCESSING ERRORS | (1) # | 17 | 3 | 1 | |
| | (2) % | 4.84% | 1.90% | 0.82% | 3.33% |
| I. THIRD PARTY LIABILITY ERRORS | (1) # | 10 | 15 | 1 | |
| | (2) % | 2.85% | 9.49% | 0.82% | 4.12% |
| II NUMBER OF CASES WITH CLAIMS BY ERROR CLASSIFICATION | | | | | |
| A. CASES HAVING ONE OR MORE ERRORS | (1) # | 48 | 24 | 7 | |
| | (2) % | 16.90% | 23.08% | 10.00% | 17.25% |
| B. INELIGIBLE CASES | (1) # | 16 | 5 | 5 | |
| | (2) % | 5.63% | 4.81% | 7.14% | 5.68% |
| C. ELIGIBLE WITH ELIGIBLE MEMBERS | (1) # | | 3 | 0 | |
| | (2) % | | 2.88% | 0% | .66% |
| D. LIABILITY UNDERSTATED ERROR ONLY | (1) # | 15 | | 0 | |
| | (2) % | 5.28% | NA | 0% | 3.28% |
| E. LIABILITY OVERSTATED ERROR ONLY | (1) # | 3 | | 0 | |
| | (2) % | 1.06% | NA | 0% | .66% |
| F. LIABILITY UNDERSTATED ERROR WITH INELIGIBLE MEMBERS | (1) # | | | 0 | |
| | (2) % | | NA | 0% | |
| G. LIABILITY OVERSTATED ERROR WITH INELIGIBLE MEMBERS | (1) # | | | 0 | |
| | (2) % | | NA | 0% | |
| H. CLAIMS PROCESSING ERRORS | (1) # | 17 | 3 | 1 | |
| | (2) % | 5.99% | 2.88% | 1.43% | 5.68% |
| I. THIRD PARTY LIABILITY ERRORS | (1) # | 8 | 14 | 1 | |
| | (2) % | 2.82% | 13.46% | 1.43% | 5.02% |

TABLE I B
QUALITY CONTROL
T OF ERROR BY ERROR CLASSIFICATION
AGE 2 OF 2)

STATE Montana REPORTING PERIOD 4-77 TO 9-77

| | | STRATUM | | | TOTAL |
|---|---|---|---|---|---|
| | | MAO | AFDC | SSI | |
| III GROSS PAYMENT ERRORS | | | | | |
| A. TOTAL ERROR PAYMENTS FOR ALL ERROR CLASSIFICATIONS | (1) $ | $4010 | $2427 | $345 | $6782 |
| | (2) % | 3.84% | 17.12% | 3.60% | 5.29% |
| B. ERROR PAYMENTS FOR INELIGIBLE RECIPIENTS | (1) $ | $2871 | $750 | $137 | $3758 |
| | (2) % | 2.75% | 5.29% | 1.43% | 2.93% |
| C. ERROR PAYMENTS RESULTING FROM CASE LIABILITY UNDERSTATED ERRORS | (1) $ | $536 | $0 | $0 | $536 |
| | (2) % | 0.51% | 0% | 0% | 0.42% |
| D. ERROR PAYMENTS RESULTING FROM CLAIMS PROCESSING ERRORS | (1) $ | $366 | $14 | $7 | $387 |
| | (2) % | 0.35% | 0.10% | 0.07% | 0.30% |
| E. ERROR PAYMENTS RESULTING FROM THIRD PARTY LIABILITY ERRORS | (1) $ | $270 | $1663 | $201 | $2134 |
| | (2) % | 0.26% | 11.73% | 2.10% | 1.67% |
| IV UNDUPLICATED PAYMENT ERRORS | | | | | |
| A. TOTAL ERROR PAYMENTS FOR ALL ERROR CLASSIFICATIONS | (1) $ | $4010 | $2427 | $345 | $6782 |
| | (2) % | 3.84% | 17.12% | 3.60% | 5.29% |
| B. ERROR PAYMENTS FOR INELIGIBLE RECIPIENTS | (1) $ | $2871 | $750 | $137 | $3758 |
| | (2) % | 2.75% | 5.29% | 1.43% | 2.93% |
| C. ERROR PAYMENTS RESULTING FROM CASE LIABILITY UNDERSTATED ERRORS | (1) $ | $536 | $0 | $0 | $536 |
| | (2) % | 0.51% | 0% | 0% | 0.42% |
| D. ERROR PAYMENTS RESULTING FROM CLAIMS PROCESSING ERRORS | (1) $ | $333 | $14 | $7 | $354 |
| | (2) % | 0.32% | 0.10% | 0.07% | 0.28% |
| E. ERROR PAYMENTS RESULTING FROM THIRD PARTY LIABILITY ERRORS | (1) $ | $270 | $1663 | $201 | $2134 |
| | (2) % | 0.26% | 11.73% | 2.10% | 1.67% |
| V DOLLAR AMOUNT OF LIABILITY OVERSTATED ERRORS FOR ALL CASES | | $0 | $0 | $0 | |
| VI DOLLAR AMOUNT OF LIABILITY UNDER-STATED ERRORS FOR ALL CASES | | $536 | $0 | $0 | |

# TABLE II A

## MEDICAID QUALITY CONTROL

## DOLLAR CALUE OF ELIGIBILITY/LIABILITY ERRORS BY SOURCE OF ERROR

STATE Montana REPORTING PERIOD 4-77 TO 9-77

| LIABILITY/ELIGIBILITY ERROR | STRATUM: MAO — INELIGIBLE CASES AMOUNT -A- | MAO — INELIGIBLE CASES % -B- | MAO — LIABILITY UNDERSTATED AMOUNT -C- | MAO — LIABILITY UNDERSTATED % -D- | MAO — TOTAL AMOUNT -E- | MAO — TOTAL % -F- | AFDC — INELIGIBLE CASES AMOUNT -A- | AFDC — INELIGIBLE CASES % -B- | AFDC — LIABILITY UNDERSTATED AMOUNT -C- | AFDC — LIABILITY UNDERSTATED % -D- | AFDC — TOTAL AMOUNT -E- | AFDC — TOTAL % -F- | SSI — INELIGIBLE CASES AMOUNT -A- | SSI — INELIGIBLE CASES % -B- | SSI — LIABILITY HIGHER STATED AMOUNT -C- | SSI — LIABILITY HIGHER STATED % -D- | SSI — TOTAL AMOUNT -E- | SSI — TOTAL % -F- | TOTAL (PERCENTS ONLY) — INELIGIBLE CASES -G- | TOTAL (PERCENTS ONLY) — LIABILITY UNDER -H- | TOTAL (PERCENTS ONLY) — TOTAL -I- |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| I DOLLAR AMOUNT OF AGENCY AND BENEFICIARY ERRORS | 2871 | 100 | 536 | 100 | $3407 | 100 | 750 | 100 | 0 | 100 | 750 | 100 | 137 | 100 | 0 | 100 | 137 | 100 | 100 | 100 | 100 |
| II DOLLAR AMOUNT OF AGENCY ERRORS | | | | | | | | | | | | | | | | | | | | | |
| A. CORRECT POLICY BUT INCORRECTLY APPLIED | $3 | .10% | | | $3 | .09 | 135 | 18.00 | | | 135 | 18.00 | | | | | | | 3.67 | 0 | 3.21 |
| B. WRONG POLICY APPLIED | $58 | 2.02 | | | $58 | 1.70 | 56 | 7.47 | | | 56 | 7.47 | | | | | | | 3.03 | 0 | 2.66 |
| C. FAILURE TO TAKE INDICATED ACTION | | | | | | | | | | | | | | | | | | | | | |
| 1. INFORMATION DISREGARDED OR NOT APPLIED | $422 | 15.40 | | | $442 | 12.97 | 0 | | | | | | | | | | | | 11.76 | 0 | 10.29 |
| 2 FOLLOW UP ON INTERIM CHANGES | $12 | .42% | | | $12 | .35 | 0 | | | | | | | | | | | | .32 | 0 | .28 |
| 3 FOLLOW UP INCONSISTENT OR INCOMPLETE INFO. | $1028 | 35.81 | $99 | 18.47 | $1127 | 33.08 | 206 | 27.47 | | | 206 | 27.47 | | | | | | | 32.84 | 18.47 | 31.04 |
| 4 VERIFY WHEN REQUIRED BY AGENCY POLICY | $850 | 29.61 | $92 | 17.16 | $942 | 27.65 | 0 | | | | | | | | | | | | 22.62 | 17.16 | 21.94 |
| D. REPORTED INFORMATION INACCURATE | | | | | | | 0 | | | | | | | | | | | | 0 | 0 | 0 |
| E. ARITHMETIC COMPUTATION | | | $123 | 22.95 | $123 | 3.61 | 0 | | | | | | | | | | | | 0 | 22.95 | 2.86 |
| III DOLLAR AMOUNT OF BENEFICIARY ERRORS | | | | | | | | | | | | | | | | | | | | | |
| A. CHANGES IN CIRCUMSTANCES NOT REPORTED | $178 | 6.20 | $177 | 33.02 | $355 | 10.42 | 353 | 47.06 | | | 353 | 47.06 | 29 | 21.17 | | | 29 | 21.17 | 14.90 | 33.02 | 17.16 |
| B. INFORMATION PROVIDED IS NOT CORRECT | $292 | 10.17 | | | $292 | 8.57 | 0 | | | | | | 108 | 78.83 | | | 108 | 78.83 | 10.64 | 0 | 9.32 |
| C. INFORMATION PROVIDED IS INCOMPLETE | $8 | .28 | $45 | 8.40 | $53 | 1.56 | 0 | | | | | | 0 | | | | | | .21 | 8.40 | 1.23 |

# TABLE II B
## MEDICAID QUALITY CONTROL
## DOLLAR VALUE OF TPL AND CP ERROR BY SOURCE OF ERROR

STATE_____ REPORTING PERIOD _____ TO _____

| THIRD PARTY LIABILITY (TPL)/ CLAIMS PROCESSING (CP) ERRORS | STRATUM | | | | | | TOTAL PERCENT ONLY |
|---|---|---|---|---|---|---|---|
| | MAO | | AFDC | | SSI | | |
| | AMOUNT -A- | PERCENT -B- | AMOUNT -A- | PERCENT -B- | AMOUNT -A- | PERCENT -B- | ONLY -C- |
| I DOLLAR AMOUNT OF TPL ERRORS | $270 | 100 | $1663 | 100 | $201 | 100 | 100 |
| A. FAILURE OF CERTIFYING AGENCY TO IDENTIFY TPL | 0 | 0% | $1242 | 74.68% | 0 | 0% | 58.20% |
| B. FAILURE OF BENEFICIARY TO INFORM ABOUT POTENTIAL TPL | $138 | 51.11% | $ 400 | 24.06% | 0 | 0% | 25.21% |
| C. FAILURE OF CLAIMS PROCESS SCREENING FOR TPL | $132 | 48.89% | $ 21 | 1.26% | $201 | 100% | 16.59% |
| D. FAILURE OF STATE TO PURSUE OR INVESTIGATE TPL LEADS | | | | | | | |
| II DOLLAR AMOUNT OF CP ERRORS | $366 | 100 | $ 14 | 100 | $ 7 | 100 | 100 |
| A. COMPLETENESS OF CLAIMS (710) | $ 27 | 7.38% | $ 0 | 0% | 0 | 0% | 6.98% |
| B. INPATIENT HOSPITAL SERVICES (720) | $ 0 | 0% | $ 0 | 0% | 0 | 0% | 0% |
| C. PHYSICIAN SERVICES (730) | $ 72 | 19.67% | $ 0 | 0% | 0 | 0% | 18.60% |
| D. LONG TERM CARE (740) | $262 | 71.58% | $ 14 | 100% | $ 7 | 100% | 73.13% |
| E. PHARMACY SERVICES (750) | $ 5 | 1.37% | $ 0 | 0% | 0 | 0% | 1.29% |
| F. EPSDT SERVICES (760) | $ 0 | 0% | $ 0 | 0% | 0 | 0% | 0% |
| G. OTHER SERVICES (770) | $ 0 | 0% | $ 0 | 0% | 0 | 0% | 0% |

# TABLE III

## MEDICAID QUALITY CONTROL

## NUMBER OF CASES BY TYPE OF ERROR COMBINATION

STATE Montana REPORTING PERIOD 4-77 TO 9-77

| ERROR COMBINATIONS | STRATUM | | | | | | TOTAL PERCENT ONLY |
|---|---|---|---|---|---|---|---|
| | MAO | | AFDC | | SSI | | |
| | NUMBER A | PERCENT B | NUMBER A | PERCENT B | NUMBER A | PERCENT B | C |
| A. TOTAL NUMBER OF COMPLETED CASE REVIEWS | 351 | 100 | 158 | 100 | 122 | 100 | 100 |
| B. NO ERRORS | 276 | 78.63 | 130 | 82.28 | 113 | 92.62 | 82.25 |
| C. ELIGIBILITY* ERRORS ONLY | 27 | 7.69 | 10 | 6.33 | 7 | 5.74 | 6.97 |
| D. LIABILITY ERRORS ONLY | 21 | 5.98 | 0 | 0 | 0 | 0 | 3.33 |
| E. TPL ERRORS ONLY | 10 | 2.85 | 14 | 8.86 | 1 | .82 | 3.64 |
| F. CP ERRORS ONLY | 16 | 4.56 | 3 | 1.90 | 1 | .82 | 3.17 |
| G. ELIGIBILITY* AND LIABILITY ERRORS ONLY | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| H. ELIGIBILITY* AND CP ERRORS ONLY | 1 | .29 | 0 | 0 | 0 | 0 | .16 |
| I. ELIGIBILITY* AND TPL ERRORS ONLY | 0 | 0 | 1 | .63 | 0 | 0 | .16 |
| J. LIABILITY AND CP ERRORS ONLY | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| K. LIABILITY AND TPL ERRORS ONLY | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| L. CP AND TPL ERRORS ONLY | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| M. ELIGIBILITY*, LIABILITY, AND CP ERRORS ONLY | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| N. ELIGIBILITY*, LIABILITY, AND TPL ERRORS ONLY | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| O. LIABILITY, CP, AND TPL ERRORS ONLY | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| P. CASES WITH ELIGIBILITY, CP, AND TPL ERRORS ONLY | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Q. ELIGIBILITY*, LIABILITY, CP, AND TPL ERRORS | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

*NOTE: ELIGIBILITY ERRORS INCLUDE INELIGIBLE CASES AND MIXD ELIGIBLE CASES WITH INELIGIBLE MEMBERS.

# TABLE IV A
## MEDICAID QUALITY CONTROL
## NUMBER OF CASES WITH ELIGIBILITY/LIABILITY ERRORS BY ELEMENT OF ERROR

STATE Montana REPORTING PERIOD 4-77 to 9-77

| PROGRAM AREAS AND ELEMENTS OF ELIGIBILITY DETERMINATION | STRATUM | | | | | | TOTAL PERCENT ONLY C |
|---|---|---|---|---|---|---|---|
| | MAO | | AFDC * | | SSI | | |
| | NUMBER A | PERCENT B | NUMBER A | PERCENT B | NUMBER A | PERCENT B | |
| I ALL CASES WITH ELIGIBILITY/ LIABILITY ERRORS | 50 | 100% | 11 | 100% | 7 | 100% | 100% |
| II ALL CASES WITH BASIC REQUIREMENT ERRORS | | | | | | | |
| A. AGE (110) | 1 | 2% | | | | | 1.47 |
| B. CITIZENSHIP ALIENAGE (120) | | | | | | | |
| C. RESIDENCY (130) | 1 | 2% | | | | | 1.47 |
| D. LIVING ARRANGEMENTS (140) | 6 | 12% | 4 | 36.36 | | | 14.71 |
| E. DEPRIVATION (151 - 154) | 1 | 2% | | | | | 1.47 |
| F. BLINDNESS/DISABILITY DETERMINATION (160) | 1 | 2% | | | | | 1.47 |
| G. MARITAL STATUS (170) | | | | | | | |
| H. OTHER CATEGORICAL RELATIONSHIP REQUIREMENT (180) | | | | | | | |
| III ALL CASES WITH RESOURCE ERRORS | | | | | | | |
| A. REAL PROPERTY (210) | 1 | 2% | | | 1 | 14.29 | 2.94 |
| B. LIQUID ASSETS (221 - 224) | 6 | 12% | 1 | 9.09 | 1 | 14.29 | 11.76 |
| C. LIFE INSURANCE (230) | | | | | 1 | 14.29 | 1.47 |
| D. MEDICAL INSURANCE (240) | | | | | | | |
| E. OTHER PERSONAL PROPERTY (250) | | | | | | | |
| F. DISPOSAL OF PROPERTY (260) | | | | | | | |
| IV ALL CASES WITH INCOME ERRORS | | | | | | | |
| A. EARNED INCOME (310) | 2 | 4% | | | 2 | 28.57 | 5.88 |
| B. SOCIAL BENEFITS (320) | 6 | 12% | | | | | 8.82 |
| C. OTHER GOVERNMENT PROGRAM BENEFITS (331 - 333) | 7 | 14% | | | | | 10.29 |
| D. PENSIONS OR OTHER BENEFITS (340) | 1 | 2% | | | | | 1.47 |
| E. SUPPORT PAYMENTS (350) | 2 | 4% | 1 | 9.09 | | | 4.41 |
| F. INCOME - IN-KIND OR DEEMED (360) | | | | | 2 | 28.57 | 2.94 |
| G. OTHER INCOME (370) | 3 | 6% | | | | | 4.41 |

# TABLE IV A
## MEDICAID QUALITY CONTROL
## NUMBER OF CASES WITH ELIGIBILITY/LIABILITY ERRORS BY ELEMENT OF ERROR

STATE_____ REPORTING PERIOD_____TO_____

| PROGRAM AREAS AND ELEMENTS OF ELIGIBILITY DETERMINATION | STRATUM | | | | | | TOTAL PERCENT ONLY C |
|---|---|---|---|---|---|---|---|
| | MAO | | AFDC | | SSI | | |
| | A NUMBER | B PERCENT | A NUMBER | B PERCENT | A NUMBER | B PERCENT | |
| V ALL CASES WITH COMPUTATION OF FINANCIAL ELIGIBILITY ERRORS | | | | | | | |
| A. COMPUTATION OF GROSS INCOME (410) | 2 | 4% | | | | | 2.94 |
| B. DEDUCTIONS/COUNTABLE INCOME (420) | 2 | 4% | | | | | 2.94 |
| C. ARITHMETIC COMPUTATION (430) | | | T | | | | |
| D. BENEFICIARY LIABILITY DETERMINATION (440) | 5 | 10% | | | | | 7.35 |
| VI ALL CASES WITH OTHER MEDICAID COVERAGE REQUIREMENT ERRORS | | | | | | | |
| A. AFDC RELATED BUDGETARY ALLOWANCE (510) | | | | | | | |
| B. AFDC SPECIAL NEEDS (521 - 525) | | | | | | | |
| C. GRANDFATHERED COVERAGE PROVISIONS (530) | | | | | | | |
| D. OTHER STATE MEDICAID CRITERIA (540) | 3 | 6% | | | | | 4.41 |
| VII ALL CASES WITH UNSPECIFIED ERRORS (999) (WIN) | | | 5 | 45.46 | | | 7.35 |

* Five ADC cases are ineligible due to failure to register for or participate in the WIN program. (45.46%)

# TABLE IV B
## MEDICAID QUALITY CONTROL
## DOLLAR AMOUNT OF ELIGIBILITY/LIABILITY ERRORS BY ELEMENT OF ERROR

STATE Montana REPORTING PERIOD 4-77 to 9-77

| PROGRAM AREAS AND ELEMENTS OF ELIGIBILITY DETERMINATION | STRATUM | | | | | | TOTAL PERCENT ONLY C |
|---|---|---|---|---|---|---|---|
| | MAO | | AFDC* | | SSI | | |
| | AMOUNT A | PERCENT B | AMOUNT A | PERCENT B | AMOUNT A | PERCENT B | |
| I ALL CASES WITH ELIGIBILITY/LIABILITY ERRORS | $3407 | 100% | $750 | 100% | $137 | 100% | 100% |
| II ALL CASES WITH BASIC REQUIREMENT ERRORS | | | | | | | |
| A. AGE (110) | | | | | | | |
| B. CITIZENSHIP ALIENAGE (120) | 274 | 8.04 | | | | | 6.38 |
| C. RESIDENCY (130) | 56 | 1.64 | $475 | 63.33 | | | 12.37 |
| D. LIVING ARRANGEMENTS (140) | 56 | 1.64 | | | | | 1.30 |
| E. DEPRIVATION (151 - 154) | | | | | | | |
| F. BLINDNESS/DISABILITY DETERMINATION (160) | | | | | | | |
| G. MARITAL STATUS (170) | | | | | | | |
| H. OTHER CATEGORICAL RELATIONSHIP REQUIREMENT (180) | | | | | | | |
| III ALL CASES WITH RESOURCE ERRORS | | | | | | | |
| A. REAL PROPERTY (210) | 567 | 16.64 | | | $38 | 27.74 | 14.09 |
| B. LIQUID ASSETS (221 - 224) | 1776 | 52.13 | $45 | 6.00 | $11 | 8.03 | 42.66 |
| C. LIFE INSURANCE (230) | | | | | $39 | 28.47 | .91 |
| D. MEDICAL INSURANCE (240) | | | | | | | |
| E. OTHER PERSONAL PROPERTY (250) | | | | | | | |
| F. DISPOSAL OF PROPERTY (260) | | | | | | | |
| IV ALL CASES WITH INCOME ERRORS | | | | | | | |
| A. EARNED INCOME (310) | 24 | .70 | | | $20 | 14.60 | 1.03 |
| B. SSI BENEFITS (320) | 173 | 5.08 | | | | | 4.03 |
| C. OTHER GOVERNMENT PROGRAM BENEFITS (331 - 335) | 148 | 4.34 | | | | | 3.44 |
| D. PENSIONS OR OTHER BENEFITS (340) | 13 | .38 | | | | | .30 |
| E. SUPPORT PAYMENTS (350) | 117 | 3.43 | | | | | 2.72 |
| F. INCOME - IN-KIND OR DEEMED (360) | | | | | $29 | 21.16 | .68 |
| G. OTHER INCOME (370) | 70 | 2.06 | | | | | 1.63 |

# TABLE IV B
## MEDICAID QUALITY CONTROL
## DOLLAR AMOUNT OF ELIGIBILITY/LIABILITY ERRORS BY ELEMENT OF ERROR

STATE_____ REPORTING PERIOD_____TO_____

| PROGRAM AREAS AND ELEMENTS OF ELIGIBILITY DETERMINATION | STRATUM | | | | | | TOTAL PERCENT ONLY c |
|---|---|---|---|---|---|---|---|
| | MAO | | AFDC | | SSI | | |
| | A AMOUNT | B PERCENT | A AMOUNT | B PERCENT | A AMOUNT | B PERCENT | |
| V ALL CASES WITH COMPUTATION OF FINANCIAL ELIGIBILITY ERRORS | | | | | | | |
| A. COMPUTATION OF GROSS INCOME (410) | | | | | | | |
| B. DEDUCTIONS/COUNTABLE INCOME (420) | 3 | .09 | | | | | .07 |
| C. ARITHMETIC COMPUTATION (430) | | . | | | | | |
| D. BENEFICIARY LIABILITY DETERMINATION (440) | 118 | 3.46 | | | | | 2.75 |
| VI ALL CASES WITH OTHER MEDICAID COVERAGE REQUIREMENT ERRORS | | | | | | | |
| A. AFDC RELATED BUDGETARY ALLOWANCE (510) | | | | | | | |
| B. AFDC SPECIAL NEEDS (521 - 525) | | | | | | | |
| C. GRANDFATHERED COVERAGE PROVISIONS (530) | | | | | | | |
| D. OTHER STATE MEDICAID CRITERIA (540) | 12 | .35 | | | | | .28 |
| VII ALL CASES WITH UNSPECIFIED ERRORS (999) WIN | | | 230 | 30.67 | | | 5.36 |

* For Project purposes, ineligibility occurred with non-registration or participation in WIN program. Five ADC cases fall into this category, with a resulting loss of $230. (30.67%)

# TABLE V
## MEDICAID QUALITY CONTROL
## NUMBER OF SAMPLE CASES BY THIRD PARTY LIABILITY STATUS

STATE Montana

REPORTING PERIOD 4-77 TO 9-77

| THIRD PARTY LIABILITY STATUS | STRATUM | | | | | | TOTAL |
|---|---|---|---|---|---|---|---|
| | MAO | | AFDC | | SSI | | |
| | NUMBER -A- | PERCENT -B- | NUMBER -A- | PERCENT -B- | NUMBER -A- | PERCENT -B- | PERCENT ONLY -C- |
| I ALL SAMPLE CASES FOR WHICH REVIEWS HAVE BEEN COMPLETED | 351 | 100 | 158 | 100 | 122 | 100 | 100 |
| II NO TPL PRESENT | 317 | 90.13 | 131 | 82.91 | 118 | 96.72 | 89.70 |
| III TPL PRESENT - NO CLAIMS FOR THE REVIEW MONTH | 6 | 1.71 | 5 | 3.17 | 0 | 0 | 1.74 |
| IV TPL PRESENT - DOLLAR AMOUNT VERIFIED | 28 | 7.98 | 22 | 13.92 | 4 | 3.28 | 8.56 |
| V TPL UNCERTAIN - THIRD PARTY NOT VERIFIED | 0 | 0% | 0 | 0% | 0 | 0% | 0% |
| VI TPL PRESENT - DOLLAR AMOUNT CANNOT BE DETERMINED | 0 | 0% | 0 | 0% | 0 | 0% | 0% |

# TABLE VI

## MEDICAID QUALITY CONTROL

## DOLLAR AMOUNT OF THIRD PARTY LIABILITY ERROR BY TYPE OF SERVICE

STATE Montana REPORTING PERIOD 4-77 TO 9-77

| TYPE OF SERVICE | STRATUM | | | | | | TOTAL |
|---|---|---|---|---|---|---|---|
| | MAO | | AFDC | | SSI | | |
| | AMOUNT -A- | PERCENT -B- | AMOUNT -A- | PERCENT -B- | AMOUNT -A- | PERCENT -B- | PERCENT -C- |
| I ALL SERVICES | $270 | 100 | $1663 | 100 | $201 | 100 | 100 |
| II INSTITUTIONAL SERVICES | | | | | | | |
| A. GENERAL HOSPITALS (01) | $166 | 61.48 | $1039 | 62.48 | $149 | 74.13 | 63.45 |
| B. MENTAL HOSPITALS (02) | 0 | | 0 | | 0 | | |
| C. SKILLED NURSING FACILITIES (03) | 0 | | 0 | | 0 | | |
| D. FACILITIES FOR THE MENTALLY RETARDED (04) | 0 | | 0 | | 0 | | |
| E. ICF SERVICES IN ALL OTHER INSTITUTIONS (05) | 0 | | 0 | | 0 | | |
| III NON-INSTITUTIONAL SERVICES | | | | | | | |
| A. PHYSICIAN'S SERVICES (11) | $5 | 1.85 | $307 | 18.46 | 0 | | 14.62 |
| B. DENTAL SERVICES (12) | 0 | | $133 | 8.00 | 0 | | 6.23 |
| C. OTHER PRACTITIONER'S SERVICES (13) | 0 | | 0 | | $50 | 24.88 | 2.34 |
| D. OUTPATIENT HOSPITAL SERVICES (14) | $14 | 5.19 | $60 | 3.60 | 0 | | 3.47 |
| E. CLINIC SERVICES (15) | 0 | | 0 | | 0 | | |
| F. LABORATORY AND RADIOLOGICAL SERVICES (16) | $55 | 20.37 | $61 | 3.67 | $2 | .99 | 5.53 |
| G. HOME HEALTH SERVICES (17) | 0 | | 0 | | 0 | | |
| H. PRESCRIBED DRUGS (18) | 0 | | $63 | 3.79 | 0 | | 2.95 |
| I. FAMILY PLANNING SERVICES (19) | 0 | | 0 | | 0 | | |
| J. OTHER SERVICES (20) | $30 | 11.11 | 0 | | 0 | | 1.41 |

# TABLE VII

## MEDICAID QUALITY CONTROL

## DOLLAR AMOUNT IN ERROR BY TYPE OF THIRD PARTY LIABILITY

STATE Montana REPORTING PERIOD 4-77 TO 9-77

| TYPE OF THIRD PARTY LIABILITY | STRATUM | | | | | | TOTAL PERCENT ONLY -C- |
|---|---|---|---|---|---|---|---|
| | MAO | | AFDC | | SSI | | |
| | AMOUNT -A- | PERCENT -B- | AMOUNT -A- | PERCENT -B- | AMOUNT -A- | PERCENT -B- | |
| I ALL TPL TYPES | $270 | 100% | $1663 | 100% | $201 | 100% | 100% |
| II HEALTH INSURANCE | $270 | 100% | $ 21 | 1.26% | $201 | 100% | 23.06% |
| III MEDICARE | 0 | 0% | 0 | 0% | 0 | 0% | 0% |
| IV OTHER GOVERNMENT PROGRAMS | 0 | 0% | 0 | 0% | 0 | 0% | 0% |
| V CASUALTY INSURANCE | 0 | 0% | 0 | 0% | 0 | 0% | 0% |
| VI OTHER THIRD PARTIES (Liable Absent Fathers) | 0 | 0% | $1642 | 98.74% | 0 | 0% | 76.94% |

Issue Date _____

# TABLE VIII

## MEDICAID QUALITY CONTROL

## CLAIMS PROCESSING ERROR CODE FREQUENCY ANALYSIS

STATE Montana

REPORTING PERIOD 4-77 TO 9-77

| ELEMENT IN ERROR | PERCENT DISTRIBUTION OF ERROR BY | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | ELEMENT CODE A | NATURE CODE | | | | | | | | | |
| | | 01 $-B_1-$ | 02 $-B_2-$ | 03 $-B_3-$ | 04 $-B_4-$ | 05 $-B_5-$ | 06 $-B_6-$ | 07 $-B_7-$ | 08 $-B_8-$ | 09 $-B_9-$ | TOTAL $-B_{10}-$ |
| I COMPLETENESS OF CLAIM (730) | 3.12 | | | | | 100% | | | | | 100 % |
| II INPATIENT HOSPITAL SERVICES (720) | | | | | | | | | | | 100 % |
| III PHYSICIAN SERVICES (750) | 24.98 | | 87.5% | | 12.5% | | | | | | 100 % |
| IV LONG TERM CARE SERVICES (760) | 68.78 | | 39.86 | 4.54 | | 55.60 | | | | | 100 % |
| V PHARMACY SERVICES (790) | 3.12 | | | 100% | | | | | | | 100 % |
| VI EPSDT SERVICES (770) | | | | | | | | | | | 100 % |
| VII OTHER SERVICES (770) | | | | | | | | | | | 100 % |

# TABLE IX A
## MEDICAID QUALITY CONTROL
## CASE CHARACTERISTICS FOR BOTH CASES WITH AND CASES WITHOUT ELIGIBILITY/LIABILITY ERRORS

STATE Montana REPORTING PERIOD 4-77 TO 9-77

| CHARACTERISTIC | CASES WITH ERROR | | CASES WITHOUT ERROR *** | |
|---|---|---|---|---|
| | NUMBER | PERCENT | NUMBER | PERCENT |
| I TOTAL | 68 | 100 | 448 | 100 |
| II TYPE OF MOST RECENT ACTION * | (61) | | | |
| A. APPROVED APPLICATION | 33 | 54.10 | 184 | 41.07 |
| B. REDETERMINATION | 28 | 45.90 | 264 | 58.93 |
| III NUMBER OF MONTHS SINCE MOST RECENT ACTION * | (61) | | | |
| A. THREE OR FEWER | 31 | 50.82 | 208 | 46.43 |
| B. FOUR TO SIX | 16 | 26.23 | 113 | 25.22 |
| C. SEVEN TO NINE | 4 | 6.56 | 59 | 13.17 |
| D. TEN TO TWELVE | 4 | 6.56 | 30 | 6.70 |
| E. THIRTEEN OR MORE | 6 | 9.84 | 38 | 8.48 |
| IV NUMBER OF PERSONS IN HOUSEHOLD ** | (67) | | | |
| A. ONE | 42 | 62.69 | 244 | 54.46 |
| B. TWO | 9 | 13.43 | 53 | 11.83 |
| C. THREE | 5 | 8.20 | 46 | 10.27 |
| D. FOUR | 5 | 8.20 | 33 | 7.37 |
| E. FIVE | 3 | 4.92 | 30 | 6.70 |
| F. SIX | 0 | | 10 | 2.23 |
| G. SEVEN | 2 | 2.99 | 13 | 2.90 |
| H. EIGHT | 0 | | 13 | 2.90 |
| I. NINE | 1 | 1.49 | 4 | .90 |
| J. TEN OR MORE | 0 | | 2 | .45 |

* This data not available for SSI cases, percentages based on ADC & MAO cases.
** Data not available for one MAO error case.
*** No data available on SSI cases without errors.

# TABLE IX B
# MEDICAID QUALITY CONTROL
## CASE CHARACTERISTICS FOR BOTH CASES WITH AND CASES WITHOUT ELIGIBILITY/LIABILITY ERRORS

STATE Montana REPORTING PERIOD 4-77 TO 9-77

| CHARACTERISTIC | CASES WITH ERROR | | CASES WITHOUT ERROR*** | |
|---|---|---|---|---|
| | NUMBER | PERCENT | NUMBER | PERCENT |
| V NUMBER OF PERSONS IN MEDICAID ASSISTANCE GROUP | | | | |
| A. ONE | 50 | 73.53 | 271 | 60.49 |
| B. TWO | 7 | 10.29 | 95 | 21.21 |
| C. THREE | 5 | 7.35 | 44 | 9.82 |
| D. FOUR | 3 | 4.62 | 20 | 4.46 |
| E. FIVE | 1 | 1.47 | 8 | 1.79 |
| F. SIX | 1 | 1.47 | 4 | .89 |
| G. SEVEN | 1 | 1.47 | 2 | .45 |
| H. EIGHT | | | 3 | .67 |
| I. NINE | | | 1 | .22 |
| J. TEN OR MORE | | | | |
| VI TYPES OF INCOME PRESENT** | | | | |
| A. EARNED INCOME | 7 | 10.45 | 40 | 8.93 |
| B. RSDI BENEFITS | 41 | 61.19 | 206 | 45.98 |
| C. OTHER GOVERNMENT BENEFIT PROGRAMS | 17 | 25.37 | 74 | 16.52 |
| D. PENSIONS AND OTHER BENEFITS (combined) | 17 | 25.37 | 40 | 8.93 |
| E. OTHER UNEARNED INCOME (combined) | | | | |

** Data not available for one MAO error case.
*** No data available for non-error SSI cases.

# TABLE IX B
# MEDICAID QUALITY CONTROL
## CASE CHARACTERISTICS FOR BOTH CASES WITH AND CASES WITHOUT ELIGIBILITY/LIABILITY ERRORS

| CHARACTERISTIC | CASES WITH ERROR | | CASES WITHOUT ERROR | |
|---|---|---|---|---|
| | NUMBER | PERCENT | NUMBER | PERCENT |
| VII TYPES OF RESOURCES AVAILABLE ** | | | | |
| A. REAL PROPERTY | 9 | 13.43 | 38 | 8.48 |
| ~~B. OTHER PERSONAL PROPERTY~~ | | | | |
| C. LIFE INSURANCE | 14 | 20.90 | 64 | 14.29 |
| D. MEDICAL INSURANCE | 8 | 11.94 | 40 | 8.93 |
| E. LIQUID ASSETS (and other personal assets) | 41 | 61.19 | 237 | 52.90 |
| VIII BASIS FOR CATEGORICAL RELATIONSHIP | | | | |
| A. SSI RELATED | 45 | 66.18 | 327 | 58.08 |
| B. AFDC RELATED | 15 | 22.06 | 172 | 30.56 |
| C. NEEDY INDIVIDUAL UNDER 21 | 8 | 11.76 | 64 | 11.36 |

** Does not include SSI cases without errors

# TABLE IX B
## MEDICAID QUALITY CONTROL
## CASE CHARACTERISTICS - ELIGIBILITY/LIABILITY ERROR CASES ONLY

STATE Montana REPORTING PERIOD 4-77 TO 9-77

| CHARACTERISTIC | ELIGIBILITY/LIABILITY ERRORS | |
|---|---|---|
| | NUMBER | PERCENT |
| I AGE OF ERROR - TOTAL | | 100% |
| A. 3 MONTHS OR FEWER | | |
| B. 4 TO 6 MONTHS | | |
| C. 7 TO 9 MONTHS | Data not collected by Project. | |
| D. 10 TO 12 MONTHS | | |
| E. 13 OR MORE MONTHS | | |
| II RELATIONSHIP OF DATE OF MOST RECENT ERROR TO DATE OF MOST RECENT ACTION - TOTAL | 68 | 100% |
| A. BEFORE | 25 | 36.77 |
| B. COINCIDENT | 19 | 27.94 |
| C. AFTER | 24 | 35.29 |
| 1. 3 MONTHS OR FEWER | | |
| 2. 4 TO 6 MONTHS | Data not collected by Project. | |
| 3. 7 TO 9 MONTHS | | |
| 4. 10 TO 12 MONTHS | | |
| 5. 13 OR MORE MONTHS | | |

Issue Date _____

TABLE X
MEDICAID QUALITY CONTROL
UNIVERSE DATA BY STRATUM OR SUBSTRATUM

STRATUM SSI

SUBSTRATUM _____

STATE Montana REPORTING PERIOD 4-77 TO 9-77

| MONTH | NUMBER OF CASES | DOLLAR PAYMENTS |
|---|---|---|
| 1. April | 23 | $ 1202 |
| 2. May | 19 | 2825 |
| 3. June | 18 | 489 |
| 4. July | 21 | 1017 |
| 5. August | 20 | 2234 |
| 6. September | 21 | 1822 |

Issue Date

TABLE X
MEDICAID QUALITY CONTROL
UNIVERSE DATA BY STRATUM OR SUBSTRATUM

STRATUM MAO

SUBSTRATUM

STATE Montana REPORTING PERIOD 4-77 TO 9-77

| MONTH | NUMBER OF CASES | DOLLAR PAYMENTS |
|---|---|---|
| 1. April | 66 | $ 18,718 |
| 2. May | 57 | 18,050 |
| 3. June | 57 | 16,945 |
| 4. July | 56 | 15,730 |
| 5. August | 56 | 16,233 |
| 6. September | 59 | 18,702 |

Issue Date

TABLE X
MEDICAID QUALITY CONTROL
UNIVERSE DATA BY STRATUM OR SUBSTRATUM

STRATUM ADC

SUBSTRATUM

STATE Montana REPORTING PERIOD 4-77 TO 9-77

| MONTH | NUMBER OF CASES | DOLLAR PAYMENTS |
|---|---|---|
| 1. April | 30 | $ 988 |
| 2. May | 28 | 2324 |
| 3. June | 28 | 2870 |
| 4. July | 23 | 3970 |
| 5. August | 24 | 1386 |
| 6. September | 25 | 2637 |

Issue Date _____

LE XI
MEDICAID QUALITY CONTROL
CORRECTION FACTOR DATA - SAMPLE PAYMENTS

STRATUM MAO SUBSTRATUM _____

| SAMPLE | April Review Month — Payment Month | | | | | May Review Month — Payment Month | | | | | June Review Month — Payment Month | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr-Aug | Sep | Oct | Nov | Dec | May-Sep | Oct | Nov | Dec | Jan | Jun-Oct | Nov | Dec | Jan |
| DOLLARS PAID FOR ALL CASES IN SAMPLE | $18,266 | $452 | $0 | | | $18,020 | $12 | $18 | | | $16,929 | $1 | $15 | |
| DOLLARS PAID FOR INELIGIBLE RECIPIENTS CASES IN THE SAMPLE | $375 | $10 | $0 | | | $56 | $12 | $0 | | | $893 | $0 | $6 | |

| SAMPLE | July Review Month — Payment Month | | | August Review Month — Payment Month | | September Review Month — Payment Month |
|---|---|---|---|---|---|---|
| | Jul-Nov | Dec | Jan | Aug-Dec | Jan | Sept - Jan |
| DOLLARS PAID FOR ALL CASES IN SAMPLE | $15,282 | $413 | $35 | $15,716 | $55 | $18,227 |
| DOLLARS PAID FOR INELIGIBLE RECIPIENTS CASES IN THE SAMPLE | $117 | $0 | $23 | $292 | $0 | $1071 |

Issue Date: _____

# TABLE XI
## MEDICAID QUALITY CONTROL
## CORRECTION FACTOR DATA - SAMPLE PAYMENTS

STRATUM ADC SUBSTRATUM _____

| SAMPLE | April Review Month | | | | | May Review Month | | | | | June Review Month | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Payment Month | | | | | Payment Month | | | | | Payment Month | | | |
| | Apr-Aug | Sep | Oct | Nov | Dec | May-Sep | Oct | Nov | Dec | Jan | Jun-Oct | Nov | Dec | Jan |
| DOLLARS PAID FOR ALL CASES IN SAMPLE | $847 | $73 | $68 | | | $2261 | $0 | $63 | | | $2851 | $29 | $0 | |
| DOLLARS PAID FOR INELIGIBLE RECIPIENTS CASES IN THE SAMPLE | $212 | $40 | $0 | | | $11 | $0 | $0 | | | $0 | $24 | $0 | |

| SAMPLE | July Review Month | | | August Review Month | | September Review Month |
|---|---|---|---|---|---|---|
| | Payment Month | | | Payment Month | | Payment Month |
| | Jul-Nov | Dec | Jan | Aug-Dec | Jan | Sept - Jan |
| DOLLARS PAID FOR ALL CASES IN SAMPLE | $793 | $75 | $102 | $1370 | $1370 | $1961 |
| DOLLARS PAID FOR INELIGIBLE RECIPIENTS CASES IN THE SAMPLE | $134 | $0 | $0 | $0 | $0 | $329 |

Issue Date: _____

# TABLE XI
## MEDICAID QUALITY CONTROL
## CORRECTION FACTOR DATA - SAMPLE PAYMENTS

STRATUM SSI _____ SUBSTRATUM _____

| SAMPLE | April Review Month | | | | | May Review Month | | | | | June Review Month | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Payment Month | | | | | Payment Month | | | | | Payment Month | | | |
| | Apr-Aug | Sep | Oct | Nov | Dec | May-Sep | Oct | Nov | Dec | Jan | Jun-Oct | Nov | Dec | Jan |
| DOLLARS PAID FOR ALL CASES IN SAMPLE | $1201 | $1 | $0 | | | $2509 | $25 | $296 | | | $489 | $0 | $0 | |
| DOLLARS PAID FOR INELIGIBLE RECIPIENTS CASES IN THE SAMPLE | $29 | $0 | $0 | | | $0 | $0 | $0 | | | $50 | $0 | $0 | |

| SAMPLE | July Review Month | | | August Review Month | | September Review Month |
|---|---|---|---|---|---|---|
| | Payment Month | | | Payment Month | | Payment Month |
| | Jul-Nov | Dec | Jan | Aug-Dec | Jan | Sept - Jan |
| DOLLARS PAID FOR ALL CASES IN SAMPLE | $991 | $0 | $26 | $2143 | $2143 | $1071 |
| DOLLARS PAID FOR INELIGIBLE RECIPIENTS CASES IN THE SAMPLE | $0 | $0 | $0 | $0 | $0 | $58 |

MEDICAID CORRECTIVE ACTION REPORT

This Corrective Action Report is based on the findings of 705 cases reviewed by the Montana Medicaid Demonstration Project. The following errors reported should be useful in implementing corrective actions regarding misspent Medicaid dollars.

Seventy-four (74) cases of 705 sampled were dropped for various reasons, so findings are based on 631 cases (122 of 123 SSI, 158 of 177 ADC cases, and 351 of 405 MAO cases). Eligibility findings, TPL review and CP are complete for all 631 cases.

I. ADC ERRORS:

A. Eligibility Errors*

One hundred fifty-eight (158) ADC cases have been reviewed for eligibility to receive Medicaid. Nineteen ADC cases were dropped. It has been determined that two cases were totally ineligibile, while two additional cases were eligible with ineligible members. Thus, 2.5% of cases completed have errors resulting in ineligibility. $385 was misspent due to eligibility errors, or 2.7% of $14,175 spent within the ADC sample.

The two cases determined to be totally ineligible were due to 1) liquid assets exceeding prescribed limits (an agency error, policy incorrectly applied) and 2) support payments were made, resulting in excess income (a client error, information given incorrect).

In the two cases with ineligible members, errors occurred in basic program requirements where, in one case, the child was not related to the

* For corrective action purposed, six ADC cases with WIN errors are not included as ineligible cases.

payee (an agency error, reported information disregarded), while in the other case, the father was in the home (a client error, not reported to agency).

B. Third Party Liability Errors

Third Party review has been completed on all ADC cases. Of 158 cases reviewed, 27 had a potential liable third party; either an absent father or health insurance. Sixteen cases had liable absent fathers, seven cases had health insurance available, and four cases had both liable absent fathers and health insurance.

In regard to cases with liable absent fathers, eight cases were determined to have utilized absent fathers properly; however, six of these cases had no claims. Four cases had a liable absent father not known. These are client related errors. In these cases, $153 was lost. The remaining eight cases had fathers known but not utilized. Errors occurred in these cases for a variety of reasons. In all eight cases, even though a liable father was known to the agency, no third party indicator appears on the eligibility file; thus, no pending of claims occurs. In these cases, it could also be considered a recipient error, in that providers are not notified of liable absent fathers. Provider errors occur, in this area, when providers do not bill the liable absent father. In any case, $1427 was lost due to absent fathers known to the agency and not utilized. Total dollars lost because of liable absent fathers amount to $1580, or 11.2% of the total dollars spent in the ADC sample.

Eleven cases show a presence of health insurance (includes four cases with liable absent fathers). Eight cases had health insurance utilized properly; of these, four had no claims. One case had health

insurance not known to the agency, but no dollars were lost because of no claims. In another case, health insurance was known, and the provider billed Medicaid and third party. The claim was not pended, Medicaid paid, and $21 was lost. The final case showed a client error in not reporting the presence of health insurance to the agency and provider, resulting in a loss of $62.

In summation, a total of $1642 was lost due to TPL errors, or 11.6% of funds expended in the ADC sample.

C. Claims Processing Errors

All CP errors in the ADC sample fell into the reasonableness of payment category. Three ADC cases had claims paid in error. They include an overpaid dental service (fillings, $8) for a total of $14. This represents .1% of monies expended in the ADC sample.

In summation, a total of $2041 was misspent in the ADC sample. This represents 14.4% of all monies expended in this sample strata. The ADC case error rate is 13.9%, with 22 of 158 cases having errors.

II. MAO ERRORS:

A. Eligibility Errors

1. Ineligibles:

All MAO cases have undergone review for eligibility. Of 405 cases completed, 54 have been dropped. Of cases completed, not including drops (351 cases), 28 are totally ineligible, representing a dollar loss of $2871. This represents 2.8% of dollars spent ($104,511) in the MAO sample strata.

Ineligibility occurs in five categories: 1) Basic program requirements, 2) Resources, 3) Income, 4) Computation of financial eligibility, and 5) Other Medicaid program requirements.

For ineligible MAO cases, nine are nursing home cases, nineteen are medically needy (including seven related to foster care). The nine nursing home cases represent the bulk of money lost due to ineligibility ($2617 or 91.2%).

Ten cases had errors in the area of basic program requirements. Seven of these ten cases were related to foster care, with six in error due to the fact that the client was no longer in foster care. The other foster home case in error was ineligible because the client was over age. In all foster home cases, the error is attributed to the agency for lack of follow-up. The other three cases with errors in this category included one case with no deprivation factor in that the father returned to the home; the second case being in error due to no verification from the Disability Determination Bureau indicating disability; with the third case in error due to residency requirements. The Medicaid paid, in this case, was referred to the State of California for repayment. Again, all cases in error were due to agency errors in failing to verify or follow-up on provided information. $330 was lost in this category.

Seven cases had errors due to resources. These cases are all nursing home cases and account for $2343 expended in error in the MAO sample. Six of these cases were ineligible due to excessive bank accounts, with four errors attributed to the agency for failure to verify or follow-up on information provided. Two client errors attributed to not reporting changes in circumstances and providing incorrect information led to errors in the other two bank account cases. One case with an excess bank account also showed an

unreported increase in VA benefits. The seventh case showed a presence of real property in excess of property limitations. This case was in error due to failure of the agency to follow-up on incomplete information,

Two cases are ineligible due to increased income. Errors in these cases are due to clients not reporting increases in earned income and the receipt of Unemployment Compensation. In these two cases, the dollar loss is $14.

Six cases are ineligible due to computation of financial eligibility. Of these six cases, four cases are in error due to incorrect beneficiary liability determination (due to spend-down errors, liability not met prior to certification (two cases) and medical expenses overcounted). Two errors from the above four cases are attributed to clients for providing incorrect or incomplete information (the spend-down and medical expenses overcounted cases), while the other two cases contain agency errors by failing to follow-up on impending changes and applying the wrong policy (liability not met prior to certification case). The remaining two cases, in the computation of financial eligibility category, are in error due to too many deductions allowed and incorrect computation of gross income, both agency errors regarding policy. In this error category, a total of $116 was lost.

The final error category is other Medicaid Coverage Requirements. Three cases fell within this error type. Two of the cases were deemed ineligible in that there is no agency record of Medicaid eligibility determination. Each of these error cases is attributed to agency errors. One of these cases had claims in the

amount of $12. The third case was ineligible because the recipient did not meet the premium and the county did not close the case. This, again, is an agency error; however, there were no claims.

2. Recipient Liability Understated Errors:

Seventeen MAO cases had understated liability, representing a dollar loss of $549 or .53% of all dollars spent in MAO sample cases. Thirteen of these cases are nursing home cases. Of the seventeen cases, sixteen cases attribute errors to the income category. Ten cases are in error due to increases in VA and/or Social Security benefits. Six of these above mentioned cases had increases in Social Security, and the agencies were negligent in not following up on impending changes. Seven of the ten cases had increased BA benefits causing errors, with four error cases resulting from client errors in not reporting changes in circumstances, and three error cases resulting from agency errors in failure to verify where required by agency policy. In these cases, $275 was lost.

Two cases are in error due to other income from real estate and increases in unearned income. With these cases, the real estate is attributed to failure of the agency to follow-up on incomplete information, while the unearned income case is attributed to the client providing incomplete information. $70 was lost in this area.

The remaining five cases in error are due to the following reasons. One case showed support payments being made, thus, an increase in unearned income; a client error for not reporting changes in circumstances. The second case was in error because the receiving of pensions was not reported by the client. The third

case was also a client error in not reporting Civil Service Survivors benefits. The fourth case had an increase in earned income, with the error attributed to the agency for failure to follow-up on incomplete information. The final case in error was the only case not in the income related error category, but in the computation of financial liability category. It was in error because the liability determination was incorrect, due to medical expenses undercounted; an agency error for failure to follow-up on incomplete information. In these five cases, $204 was lost.

3. Liability Overstated:

Five cases have errors due to recipient liability being overstated; however, these errors do not contribute to dollar losses in the Medicaid program.

For all dollar losses accorded to ineligibility and understated liability, an error rate of 3.3% exists (3420 ÷ 104,511). $2765 was lost due to agency errors, $655 due to client errors.

B. Third Party Liability Errors

Information on TPL is available on 351 completed cases, not including 54 dropped cases.

Twenty-six (26) MAO cases had a third party present. In eighteen cases, it was determined that the third party was utilized properly. These cases included one case with a liable absent father, one case with both a liable absent father and health insurance, and sixteen cases with health insurance. Thirteen of these cases had claims not covered by the insurance policy, the other five cases had no claims at all.

The eight error cases resulted in losses of $270, or .3% of all dollars expended in the MAO sample.

In all cases, health insurance was known to the local agency; however, in only three cases was a third party indicator in the system. For those recipients with third party indicated on the system, a total of $30 was lost. These claims were not properly pended. The other cases might be called either client or agency errors, in that clients had not informed providers of third party, or in that agencies had put no third party indicator on the system.

C. Claims Processing Errors

Claims processing information has been completed on 338 cases. Fifteen MAO cases had claims processing errors. Fourteen of these cases are nursing home cases. Eighteen claims had errors; seventeen with nursing homes. A total of $306 was lost due to claims processing errors in the MAO sample, or .3% of all funds expended in the MAO sample.

Nine claims with errors are associated with the reasonableness of payment categories. Errors occurred because: 1) nursing home overpaid by $6, 2) speech therapy overpaid by $12, 3) retroactive nursing home overpaid by $118, 4) nursing home overpaid by $8 because of understated recipient liability, 5) pharmacy overpaid by $1.00 (prescription refilled three times and overpaid 35¢ each time), 6) nursing home overpaid by $8 because of recipient liability understated, 7) physician overpaid for surgical tray by $1.00, 8) overpaid nursing home by $21 (resources too little) and 9) paid retroactive care to nursing home for 8/77 when rate increase was not in effect until 9/77.

Eight claims paid in error are associated with the compliance of claims with policy regulations. These include payment for a non-covered drug, and seven claims where nursing homes charged for supplies which are supposed to be covered in the nursing home rate. With these seven

claims, the items included catheter drainage bags, urinary drainage sets, irrigation tray dispensers and colostomy bags.

The remaining claim paid in error was for a maintenance drug issued in less than minimum quantity. The same prescription was issued three times during the month when it should have been issued only once. Overpayment then was due to dispensing fees.

In summary, a total or 68 MAO cases have errors. A total of $4010 has been spent in error in the MAO sample, for a dollar error rate of 3.8%.

III. SSI ERROR CASES:

One hundred twenty-three (123) SSI cases have been completed, including one dropped case. Nine SSI cases have errors, for a case error rate of 7.4%. Seven cases have eligibility errors for a rate of 5.7%, while one case has a claims processing error (.8%) and one case has a third party liability error (.8%).

A total of $9589 was expended on SSI cases, with $345 spent in error, for a dollar error rate of 3.6%. $137 was misspent due to eligibility errors (1.4% of all dollars spent in SSI), $201 misspent due to third party liability errors (2.1%), and $7 misspent due to claims processing errors (.07%).

A. Eligibility Errors

Seven SSI cases have eligibility errors making them all totally ineligible. All SSI errors are client related.

Three cases showed increases in unearned income resulting in errors. These cases were comprised of two deemed income cases and one in-kind income case. In these cases, client information was incorrect or unreported.

Another case showed resources in excess due to the presence of bank accounts and real property. One case showed the presence of earned income increase (this case was an SSI hold-out case whereby common law existed and the presence of the spouses deemable income was not reported). Another case showed presence of life insurance and resources in excess of SSI standards. Still another case showed presence of bank accounts in excess of standards.

All seven SSI error cases are related to resources or income in excess and unreported.

B. Third Party Liability Errors

Four SSI cases have third party indicated, three of them utilized health insurance properly. All four cases had claims. In the only error instance, health insurance was available but not known, resulting in an error of $201. There was no third party indicator on the system for this individual.

C. Claims Processing Errors

One SSI case had a CP error for $7. The claim amount exceeded the maximum limits on the fee file, a hospital outpatient visit overpaid by $7.

Regarding error findings from all aid categories, a dollar error rate of 4.98% exists ($6382 ÷ $128,142). When weighted, the program error rate is 5.5%.

IV. RECOMMENDATIONS:

The following includes the sections of recommendations to the State for program operations, technical recommendations to the Federal Government, and recommendations for management utilization.

A. State

As a result of the Montana Project experience, the following are recommendations for implementation:

1. Beginning October 1, 1978, Medicaid Quality Control will be assimiliated into the Program Integrity Bureau. With project termination, the staff will be reduced by eight persons. Staff lay-off will include 1 Project Director, 1 Program Manager, 1 Claims Examiner and 5 Quality Control Reviewers. Exhibit N describes the staffing pattern for Medicaid Quality Control implementation. A hiring freeze has recently been imposed by the Governor of Montana. Provided there are no staff terminations, Exhibit N describes the staff that will be working with the ongoing process.

2. Montana should continue to use logging systems for case tracking.

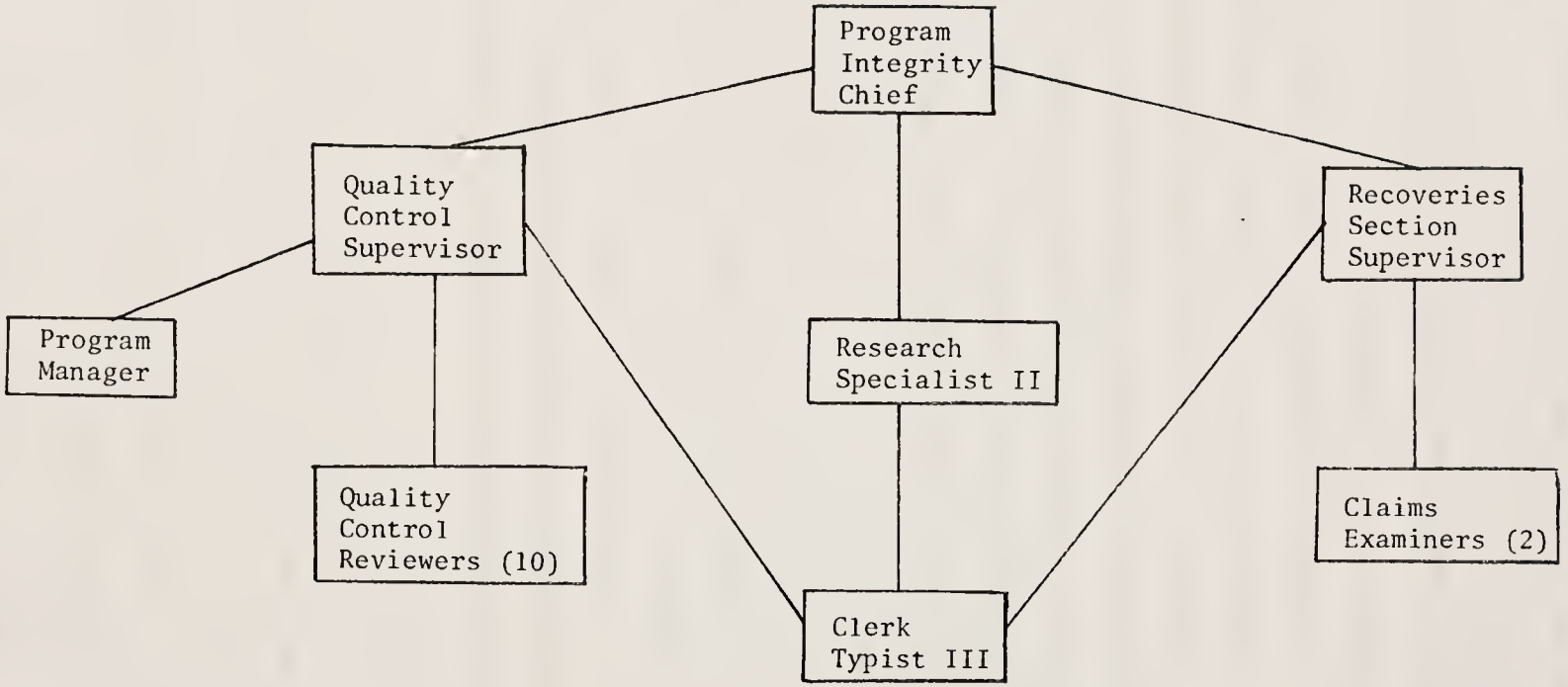
3. Montana should develop a computer program for edit of the Medicaid Quality Control Review Schedule.

4. Montana should continue to push for TPL collection with TPL inquiry.

5. Montana should continue to develop and improve the procedures for the interface of and testing for Medicaid eligibility in the cases of SSI and ADC.

6. Montana should continue to develop and improve the CP and TPL review procedures.

IMPLEMENTATION STAFFING PATTERN



7. Montana should, with the findings of Medicaid Quality Control, develop corrective action procedures for eligibility, CP and TPL errors in the programs of Medical Assistance Only, Aid to Dependent Children and Supplementary Security Income. (See Section C for further recommendations in this area.)

B. Federal

1. Montana staff recommends through pilot test experience, that a claim be defined by an invoice rather than by a line item. To define a line item as a claim would be to create arithmetic errors in both CP and TPL worksheets. Errors would be created in the computing of numbers of paid claims and numbers of services. For example, a case with five invoices might have as many as 100 line items. The line items are broken out in the summary sheets anyway; thus arbitrarily calling each line item a claim will only create confusion, and an increased probability of coding and arithmetic.

2. Montana further contends that the Claims Processing Summary Sheet causes unnecessary effort. The information contained on the summary sheet is identical to the Claims Processing Quality Control Worksheet. Thus the Claims Processing Summary Sheet form should either be dispensed with or treated as an optional support form. If both forms are treated as mandatory, claims processing information will be recorded in triplicate with the following forms:

a. Claims Processing Summary Sheet

b. Claims Processing Quality Control Worksheet

c. Review Schedule - (Page 4)

3. Montana also recommends that the Third Party Liability Worksheet be abandoned or treated as optional. This form creates

duplication of effort. The Third Party Liability Worksheet information is contained on the Medical Services & Health Benefits Worksheet Supplement as well as the Quality Control Worksheet forms. As with the CP forms, TPL information will be recorded in triplicate if all forms are mandatory:

a. Third Party Liability Worksheet

b. Medical Services & Health Benefits Worksheet Supplement

c. Review Schedule (Page 3)

4. Project staff in conjunction with Control Analysis staff redesigned the five page Review Schedule. The redesign is included as Exhibit O. The current schedule is long, with detailed interpretations for completion. Its length and detail creates a probability for error. While it gathers a multitude of information, the information may not be meaningful since the form is prone to error. If the condensed Review Schedule were implemented, report XI-B page 121 of the reports manual could not be completed. This report, "Age of Error" could be obtained from the "Recoveries Unit" if it serves any purpose to Quality Control.

5. There appears to be significant weaknesses in the Federally mandated procedure. Our recommendation would be to collect payments with inquiry. Due to the new procedure of waiting until the sixth month to start CP and TPL review, the cases would not receive preferential treatment. If the Recoveries Unit had already initiated collections, there is no error. If the procedure were combined Medicaid Quality Control could refer collections immediately to the Recoveries Unit for processing. With the procedure of inquiry with no attempt at collection Montana found:

MEDICAID QUALITY CONTROL
REVIEW SCHEDULE

Pa 1 of 4 — I. Identifying Information — Review No.

| 1. Case Name | 2. Address | 3. Case ID Number |
|---|---|---|
| 4. Review Month | 5. Date Eligibility Review Assigned | 6. Date Eligibility Review Completed |
| | | 7. Reviewer-Field |
| | | 8. Reviewer-Central |

II. Case Information
(Card 1)

| A. State Code (1 2) | B. Local Agency Code (3 4 5) | C. Review Number (6 7 8 9 10 11) | D. Review Mo. & Yr. (12 13) (14 15) |
|---|---|---|---|

E. Date of Most Recent Action (prior to date in item "D") — MO. (16 17) YR. (18 19)

F. Type of Most Recent Action (20)
1. ☐ Approved Application
2. ☐ Redetermination

G. Number of Months Between Most Recent Action and Review Month (If action concurrent with Review Month, enter 00) (21 22)

H. Categorical Relationship (check one) (23)
1. ☐ SSI Cash Assitance
2. ☐ AFDC Cash Assistance
3. ☐ Medically Needy
4. ☐ Other Non-Cash

I. Basis for Categorical Relationship (check one) (24)

SSI RELATED
1. ☐ Aged
2. ☐ Blind
3. ☐ Disabled

AFDC RELATED
4. ☐ Death
5. ☐ Incapacity
6. ☐ Unemployed father
7. ☐ Continued absence

NEEDY INDIVIDUAL UNDER 21
8. ☐ Foster Care
9. ☐ Other

| J. Medicaid Eligibility Coverage Requirement Used by Agency (code) (25 26) | K. Number of Persons in Household (27 28) | L. Number of Persons in Medicaid Assistance Grou (29 30) |
|---|---|---|

M. Does the case show the presence of any of the following elements during the Review Month?

| (a) INCOME (31 32 33 34 35) | In Case Record | | Only Known after Field Review | |
|---|---|---|---|---|
| 31 Earned Income | 1 Yes ☐ | 2 No ☐ | 3 Yes ☐ | 4 No ☐ |
| 32 RSDI Benefits | 1 Yes ☐ | 2 No ☐ | 3 Yes ☐ | 4 No ☐ |
| 33 Other Govt Benefit Programs | 1 Yes ☐ | 2 No ☐ | 3 Yes ☐ | 4 No ☐ |
| 34 Pensions or Other Benefits | 1 Yes ☐ | 2 No ☐ | 3 Yes ☐ | 4 No ☐ |
| 35 Other Unearned Income | 1 Yes ☐ | 2 No ☐ | 3 Yes ☐ | 4 No ☐ |
| (b) RESOURCES | In Case Record | | Only Known after Field Review | |
| 36 Real Property | 1 Yes ☐ | 2 No ☐ | 3 Yes ☐ | 4 No ☐ |
| 37 Other Personal Property (motor vehicle & other) | 1 Yes ☐ | 2 No ☐ | 3 Yes ☐ | 4 No ☐ |
| 38 Life Insurance | 1 Yes ☐ | 2 No ☐ | 3 Yes ☐ | 4 No ☐ |
| 39 Medical Insurance | 1 Yes ☐ | 2 No ☐ | 3 Yes ☐ | 4 No ☐ |
| 40 Liquid Assets | 1 Yes ☐ | 2 No ☐ | 3 Yes ☐ | 4 No ☐ |

## III. Eligibility Summary Findings

 Review No. _____

Q. sposition of Review (check one) [ ] 57

1. [ ] Review completed
If code 1 is checked, complete the remainder of Section IV below. If any other code is checked, no further entry is required.

Review not completed due to

2. [ ] Moved out of State since Review Month
3. [ ] Unwilling to give information
4. [ ] Unable to locate
5. [ ] Listed in Error
6. [ ] Other (explain)_____

P. For eligible cases, Medicaid eligibility coverage requirement used by reviewer (code) [ ][ ] 52 53

Q. Eligibility Review Findings

1a. Case Status [ ] 54

1. [ ] Eligible
2. [ ] Ineligible
3. [ ] Eligible w/Ineligible Members
4. [ ] Liability Understated Error Only
5. [ ] Liability Overstated Error Only
6. [ ] Liability Understated Error w/Ineligible Member(s)
7. [ ] Liability Overstated Error w/Ineligible Member(s)

1b. Case Member Status

1. Eligible Members [ ][ ] 55 56
2. Ineligible Members [ ][ ] 58 59
3. Eligible Members with Understated Liability [ ][ ] 57 60
4. Eligible Members with Overstated Liability [ ][ ] 61 62

S. Primary error resulting in ineligibility or payment status occurred:

[ ] 1. Before most recent action. [ ] 2. At time of most recent action. [ ] 3. After most recent action.

T. Does there appear to be willful misrepresentation of facts? (check one) [ ] 70

1. Yes [ ] 2. No [ ]

U. Description of Error(s) (Card 2: Duplicate columns 1-15 from card 1)

| Error | Element | Nature | Type | Error FInding* | Dollar Amount |
|---|---|---|---|---|---|
| 1. | [ ][ ][ ] 16 17 18 | [ ][ ] 19 20 | [ ][ ] 21 22 | [ ] 23 | [ ][ ][ ][ ][ ][ ] 25 26 27 28 29 30 31 |
| 2. | [ ][ ][ ] 30 31 32 | [ ][ ] 33 34 | [ ][ ] 35 36 | [ ] 37 | [ ][ ][ ][ ][ ][ ] 41 42 43 44 45 46 |
| 3. | [ ][ ][ ] 44 45 46 | [ ][ ] 47 48 | [ ][ ] 49 50 | [ ] 51 | [ ][ ][ ][ ][ ][ ] 55 56 57 58 59 60 61 |
| 4. | [ ][ ][ ] 58 59 60 | [ ][ ] 61 62 | [ ][ ] 63 64 | [ ] 65 | [ ][ ][ ][ ][ ][ ] 71 72 73 74 75 76 |
| 5. | [ ][ ][ ] 16 17 18 | [ ][ ] 19 20 | [ ][ ] 21 22 | [ ] 23 | [ ][ ][ ][ ][ ][ ] 25 26 27 28 29 30 31 |

(Card 3; Duplicate columns 1-15 from

## IV. Explanation of Eligibility Errors

| (1) Elements | (2) Nature of Error(s) | (3) State Manual Citation |
|---|---|---|
| | | |

* Note: Error Finding is redefined
1 = Element resulted in eligibility error
2 = Element resulted in liability error

(Exhibit O)



V. Summary of Third Party Liability Errors

Review No. _____

| 1. se Name | 2. Address | 3. Case ID Number |
|---|---|---|

| 4. Review Month | 5. Date TPL Review Assigned | 6. Date TPL Review Completed | 7. Reviewer |
|---|---|---|---|

(Card 4: Duplicate columns 1-15 from card 1)

. TPL Status (check one)

1. ☐ No TPL present
2. ☐ TPL present, no claims
3. ☐ TPL present, dollar amount verified
4. ☐ TPL uncertain, third party not verified
5. ☐ TPL present, dollar amount can not be determined

. Number of Claims with TPL Error ☐☐☐

J. Total Dollar Amount of TPL Errors ☐☐☐☐☐

If no claims were determined to be in error (entries in Items E, F, and G were 00), no further entry is required.

(Card 5: Duplicate columns 1-15 from card 1)

. TPL Errors by Type of Third Party Liability

| | TPL-type code | Source of Error* | dollar amount |
|---|---|---|---|
| 1. | ☐☐ | ☐ | ☐☐☐☐☐ |
| 2. | ☐☐ | ☐ | ☐☐☐☐☐ |
| 3. | ☐☐ | ☐ | ☐☐☐☐☐ |
| 4. | ☐☐ | ☐ | ☐☐☐☐☐ |
| 5. | ☐☐ | ☐ | ☐☐☐☐☐ |
| 6. | ☐☐ | ☐ | ☐☐☐☐☐ |

* Codes for Source of Error

1. Certifying Agency
2. Beneficiary
3. Claims Processing
4. Recovery Activities

(Exhibit O)

Summary of Claims Processing Errors and Unduplicated Errors

Pa 4 of 4 Review No.

| 1. Case Name | 2. Address | 3. Case ID Number |
|---|---|---|
| | | |

| 4. Review Month | 5. Date Claims Processing Review Assigned | 6. Date Claims Processing Review Completed | 7. Reviewer |
|---|---|---|---|
| | | | |

(Card 7: Duplicate columns 1-15 from card 1)

A. Number of Recipients of Medical Service During the Review Month ☐☐

B. Number of Paid Claims ☐☐☐

C. Dollar Amount of Paid Claims ☐☐☐☐☐

D. Number of Claims with CP Errors ☐☐☐

E. Dollar Amount of CP Errors ☐☐☐☐☐

If no claims were determined to be in error (entries in Items , , and , were 00), no further entry is required.

F. Description of payment errors:

| Claims with error(s) | Element | Nature | Type | Dollar Amount of Error |
|---|---|---|---|---|
| 1 | ☐☐☐ | ☐☐ | ☐☐ | ☐☐☐☐☐ |
| 2 | ☐☐☐ | ☐☐ | ☐☐ | ☐☐☐☐☐ |
| 3 | ☐☐☐ | ☐☐ | ☐☐ | ☐☐☐☐☐ |
| 4 | ☐☐☐ | ☐☐ | ☐☐ | ☐☐☐☐☐ |
| 5 | ☐☐☐ | ☐☐ | ☐☐ | ☐☐☐☐☐ |
| 6 | ☐☐☐ | ☐☐ | ☐☐ | ☐☐☐☐☐ |

G. Total Unduplicated Dollar Amount of Case Eligibility Errors ☐☐☐☐☐

H. Total Unduplicated Dollar Amount of Case Liability Errors ☐☐☐☐☐

I. Total Unduplicated Dollar Amount of Case Claims Processing Errors ☐☐☐☐☐

J. Total Unduplicated Dollar Amount of Third Party Liability Errors ☐☐☐☐☐

K. Total Unduplicated Dollar Amount of Medicaid Misspent Funds for the Case ☐☐☐☐☐

a. Some insurance companies would not respond in the absence of filing of a claim.

b. Many insurance policies include deductibles and benefit limits. Insurance companies could not assess an amount to be paid without the claim to provide an analysis for computation.

c. It is confusing to insurance companies and unprofessional for SRS to ask for information one day from one bureau and then request payment from another bureau.

d. The procedure creates duplicate work for the division. With a hiring freeze and staff shortage, this duplicate effort creates a hardship to agency staff.

C. Management Utilization

The new combined Medicaid Quality Control process provides management with error information in the areas of eligibility, CP and TPL. The new process can identify specific problems within the Medicaid eligibility system, in the programs of Medical Assitance Only, Aid to Dependent Children and Supplementary Security Income. Medical Quality Control results identify specific error patterns and types and documents error causes. Through development of error reports, corrective action procedures can be initiated. Based on the project results, the following are examples of corrective action procedures Montana may wish to develop:

1. Montana, provided additional staff could be acquired, may wish to increase the Medicaid Quality Control sample size to provide better corrective action data. (The SSI sample, in particular, is small in that the dollars sampled are about .2% of total SSI expenditures).

2. Montana may wish to develop expanded review techniques to reduce the error rate.

a. For example, an expanded desk review of cases could be sampled in counties where there appears to be a high incidence of eligibility errors. The reviews might be further refined to zero in on elements where there is a problem, such as with excess resources, improper income computations, real property, etc.

b. When CP errors become evident in a particular nursing home, a sample of claims could be reviewed for the specific nursing home.

c. Medicaid Quality Control could do an expanded sample of health insurance reviews. This sample would include cases from the three stratums and could be conducted via telephone by checking:

1) Is there a liable absent father and/or was health insurance available?

2) If so, was this resource known to the county?

3) If so, were claims pended?

3. Montana may wish to develop specific training for Eligibility Technicians based on an error results needs analysis aimed at training where there is a high incidence of error which can be attributed to particular elements of eligibility.

4. Montana may wish to implement the error prone profile system developed by Control Analysis Corporation.

5. Montana could expand the Supervisor Observation Plan whereby Eligibility Supervisors monitor the Medicaid program through a

scheduled and methodical review of cases. (This procedure was mentioned in Control Analysis Co rporations report of June 24, 1978).

6. Control Analysis Corporation also suggested the development of Priority Problems Lists (PPL). The list would initiate from the counties and would help management to focus on solutions to problems. The lists would identify those problems to which solutions might be policy changes, policy interpretations, or changes to the system.

V. PROGRAM OPERATIONS-MEDICAID QUALITY CONTROL IMPLEMENTATION

The following section is the Montana Medicaid Quality Control Procedures Manual. The contents of this manual reflects the planned procedures and quidelines for Montana implementation. The contents of this manual contains information concerning the details of Montana implementation and will serve as a reference as well as a training manual in the future.